



USAID | **HAITI**
FROM THE AMERICAN PEOPLE

Services de Santé de Qualité pour Haïti (SSQH) Central and South Contract No. AID-521-0-13-00011

FY 2015

Annual Report: October 1, 2014 – September 30, 2015



November 2015

This publication was produced for review by the United States Agency for International Development (USAID). It was produced by Pathfinder International, in collaboration with Deloitte Consulting, LLP, Zamni Lasante, Partners In Health, GHESKIO, CDS, FOSREF, and Dimagi.

Table of Contents

ACRONYMS.....	4
EXECUTIVE SUMMARY	5
INTRODUCTION.....	7
OBJECTIVE 1	8
HIV/AIDS.....	9
TUBERCULOSIS	14
FAMILY PLANNING AND REPRODUCTIVE HEALTH	20
GENDER-BASED VIOLENCE AND CHILD PROTECTION	22
COMMUNITY-BASED ACTIVITIES.....	25
OBJECTIVE 2	27
SUPPORT FOR CHWs	27
POINT-OF-CARE DIAGNOSTICS FOR HIV/TB	31
MOBILE MENTORSHIP TEAMS.....	31
OBJECTIVE 3	32
CONTINUOUS QUALITY IMPROVEMENT	32
FINANCIAL SYSTEMS.....	33
CLINICAL RECORD SYSTEMS.....	33
HEALTHCARE WASTE MANAGEMENT	34
DATA MANAGEMENT.....	34
INFECTION CONTROL.....	34
PERSONNEL MANAGEMENT.....	35
SUPERVISION.....	35
OBJECTIVE 4	37
SUPPORTING DEVELOPMENT OF DEPARTMENTAL MANAGEMENT SYSTEMS	37
RESULTS-BASED FINANCING.....	39
MANAGEMENT, MONITORING, AND ADMINISTRATION.....	41
PROJECT MANAGEMENT	41
MONITORING SYSTEMS	42
ADMINISTRATION.....	43

ENVIRONMENTAL COMPLIANCE.....	44
SUCCESS STORIES.....	45
A SECOND CHANCE FOR FAMILY PLANNING IN HAITI	45
ICC GRACE HOSPITAL MOVES THE NEEDLE ON IMPROVING QUALITY OF CARE PROCESSES FOR HIV PATIENTS.....	46
ANNEXES.....	46

ACRONYMS

ANC	Antenatal care	LTFU	Lost-to-follow-up
ART	Antiretroviral treatment	M&E	Monitoring and Evaluation
ASCP	Agent de Santé Communautaire Polyvalent	MESI	Monitoring, Evaluation and Surveillance Interface
BEST	Bien et al Santé Timoun Project	MMT	Mobile Mentoring Team
CAL	Centre avec lits (center with beds)	MNH	Maternal and Newborn Health
CAN	Centre Ambulancier National	MSPP	Ministère de la Santé Publique et de la Population
CDS	Centres pour le Développement et la Santé	NGO	Non-governmental Organization
CHW	Community health worker	OVC	Orphans and Vulnerable Children
CP	Child protection	PDI	Plan Départementale Intégré
CQI	Continuous Quality Improvement	PEPFAR	President's Emergency Plan for AIDS Relief
CSL	Centre sans lits (center without beds)	PIH	Partners in Health
CYPRESS	Capacity, Performance, Results, Sustainability	PLHIV	People living with HIV
DDS	Direction Départementale Sanitaire	PMP	Performance Monitoring Plan
DHIS2	District Health Information System 2	PMTCT	Prevention of Mother-to-Child Transmission
DPEV	Direction Programme Elargis	PNLT	Programme National de Lutte contre la Tuberculose
FP	Family Planning	RBF	Results-based financing
FOSREF	Fondation pour la Santé Reproductrice et de l'Education Familiale	SCMS	Supply Chain Management System project
GBV	Gender-based Violence	SDSH II	Santé pour le Développement et la Stabilité d'Haïti II project
GHESKIO	Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes	SSQH-CS	Services de Santé de Qualité pour Haïti Central-South project
GOH	Government of Haiti	TA	Technical assistance
GTT	Groupe Technique de Travail	TB	Tuberculosis
HTC	HIV Testing and Counseling	UADS	Unité d'Appui au Direction Sanitaire
HIFIVE	Haiti Integrated Financing for Value Chains and Enterprises project	UAS	Unités d'Arrondissement de Santé
HMIS	Health management information system	UEP	Unité d'Évaluation et de
LAPM	Long-acting and Permanent Methods	USAID	United States Agency for International Development
LMG	Leadership, Management, and Governance project	USG	United States Government
LMS	Leadership, Management, and Sustainability project	WASH	Water, Sanitation, and Hygiene
		YFS	Youth-friendly services
		ZC	Zone Ciblées
		ZL	Zanmi Lasante

EXECUTIVE SUMMARY

SSQH-CS is pleased to present its program year two (PY2) annual performance report. With critical groundwork laid in PY1, SSQH-CS sustained activities while deepening its relationship with MSPP, DDS, and health facilities and providers. Key foci during the year were improved integration of programmatic implementation and partner leveraging to affect the greatest outcomes in service delivery and health systems strengthening. Notable accomplishments include ART and PMTCT sites upgrades, the establishment of a CD4 diagnostic hub facility, the expansion of the ASCP network, the launching of the CHW Supervisor module under the mSanté program, the development of facility and departmental CQI plans, and the increase in joint supervision visits involving DDS personnel.

Overall, SSQH-CS logged progress in achieving many of its expected results. Many service delivery indicators for HIV/AIDS, TB, MCH, FP, and nutrition performed on target or even surpassed expected results, while referral network and HSS indicators excelled. Essential to this success are partnerships: MSPP/central, national programs (HIV and laboratory), individual DDS, and USG partners all played critical roles in helping the project achieve. Selected highlights from the semester are below:

Success Highlights

For **HIV/AIDS**, SSQH-CS met or surpassed annual targets for 10 indicators. Selected high performing HIV indicators are number of adults and children currently receiving ART; number of individuals who received testing and counseling services for HIV and received their test results; and percent of adults and children known to be alive and on treatment 12 months after initiation of ART. **Tuberculosis (TB)** indicators also posted impressive results, with the case notification rate in new sputum smear positive pulmonary TB cases registering well over the annual target.

SSQH-CS made convincing strides in **maternal and child health (MCH)** indicators during the year. Indicators measuring antenatal and post-partum care, including the number of women receiving at least 3 ANC visits, the prevalence of anemia, and the percent of post-partum visits within 3 days of delivery were strong for the year. Performance in the percentage of underweight children and the number of children who receive DPT3 vaccine by 12 months of age was noteworthy. The project now supports **family planning** services at all eligible facilities within the project-supported network, while the number of sites offering **GBV and child protection** services and referrals increased for the year. Finally, the total number of visits for facility or community services increased to 1,736,008 for the year.

Under **Objective 2**, the supports 1,137 **CHWs** per the catchment population of USG-supported health referral networks.

In support of **Objective 3**, SSQH-CS saw all facilities implementing **CQI Plans**, with nearly all having **CQI teams that are staffed and meet regularly**. Under **Objective 4**, all six **DDS** hold meetings at least once per quarter to analyze and use data for planning, while project-supported sites are addressing recommendations from **joint supervision** site visits.

Despite these impressive gains, PY2 witnessed challenges that tempered overall performance. Some indicators slipped from mid-point performance to fall short of their expected result. Community mobilization and support needs to help bolster demand generation of selected services, such as FP/RH services and ART care. Some gaps or delays in facility reporting prevent services to be timely counted within the MSPP health information systems, emphasizing the need to improve data quality practices.

Certain training activities were delayed during the first semester and impeded the project's ability to reach all its related targets. Delays in the Dimagi subcontract approval in the first semester unfortunately sidelined that partner and delayed new CommCare module (HIV) development and rollout. Key personnel transitions and post vacancies impacted continuity of project leadership, with the COP, M&E Specialist, and F&A Director all leaving the project during the course of the first semester. While the F&A and M&E Director positions were filled during the second semester, one Technical Director left during the second semester and interim COP leadership lasted throughout the second semester.

Looking forward to the next year, SSQH-CS will maintain support for service delivery at facilities and with the communities across the project network, while ongoing facility TA will offer targeted assistance to increase quality. Demand generation through an aggressive community mobilization strategy will move forward in PY3, while the project will realize training targets for ASCP and mSanté programs. Data quality assurance and improved reporting practices from community and facility levels remain a key concentration for the project. Finally, the procurement of supplies and equipment is necessary to help facilities deliver quality services and accurately report results on time.

INTRODUCTION

The Services de Santé de Qualité pour Haïti- Central and South (SSQH-CS) Project is a three-year (with the option of a two-year extension) health service delivery initiative in Haiti funded by the United States Agency for International Development (USAID). SSQH-CS supports the Ministère de la Santé Publique et de la Population (MSPP) to improve the health status of the Haitian population. Led by Pathfinder International, the SSQH-CS consortium includes Centres pour le Développement de la Santé (CDS); Deloitte Consulting, LLP ; Dimagi ; the Fondation pour la Santé Reproductrice et de l'Éducation Familiale (FOSREF); the Groupe Haïtien d'Étude du Syndrome de Kaposi et des Infections Opportunistes (GHESKIO); Partners In Health (PIH); and Zamni Lasante (ZL).

SSQH-CS has four objectives:

- (1) Increase the utilization of the Ministère de la Santé Publique et de la Population's integrated package of services at the primary care and community levels (particularly in rural or isolated areas;
- (2) Improve the functionality of the USG-supported health referral networks;
- (3) Facilitate the sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels; and
- (4) Strengthen departmental health authorities' capacity to manage and monitor service delivery.

SSQH-CS works in six of the ten departments in Haiti, including West, Center, South, South-East, Nippes, and Grand Anse, providing clinical and community-based services for the catchment area's nearly 2.65 million people (approximately 25% of the country's estimated 10.4 million population in 2015). Service delivery entails the provision of MSPP's Essential Package of Services, which includes services in HIV/AIDS (including clinical and psychosocial service support to Orphans and Vulnerable Children [OVC]); Tuberculosis (TB); Maternal and Child Health (MCH) (including Water, Sanitation and Hygiene [WASH], and Nutrition); and Family Planning (FP). In addition, SSQH-CS supports Gender-Based violence (GBV) and Child Protection (CP) services at selected sites, as well as the provision of training and limited support for basic critical care (accident and emergency) for project sites within the Port-au-Prince and parts of the St. Marc USAID Development Corridors. A critical link between communities and facilities reinforced and supported by SSQH-CS is the Agents de Santé Communautaires Polyvalents (ASCP), who provide first level services in MCH, FP, STI/HIV/AIDS, TB, and nutrition. SSQH expects to support 1,000 ASCPs by project's end.

Key project strategies for reaching these objectives include (1) strengthen the technical knowledge, skills, and capacity of health care providers at facility and community levels; (2) train and mentor health care leadership in management practices; (3) establish and strengthen service networks extending from the household to hospitals; (4) assess and where feasible, refurbish physical infrastructures and supply equipment to facilities; (5) promote community involvement and mobilization; and (6) implement the MSPP results-based financing (RBF) scheme.

This annual report covers the Project Year Two (PY2) activities and project results from October 2014 to September 2015. The report is divided into three main sections: performance by objective (1-4); management, monitoring, and administration; and success stories. Performance tables for indicators and semester highlight boxes are included throughout the report. The full PMP with data for indicators is in Annex A.

OBJECTIVE I

INCREASE THE UTILIZATION OF THE MSPP INTEGRATED PACKAGE OF SERVICES AT THE PRIMARY CARE AND COMMUNITY LEVELS

Annual Highlights

- ✓ 138.8% of annual target met for number of individuals who receiving testing and counseling services for HIV and received their test results
- ✓ 139.8% of annual target met for the number of adults and children currently receiving ART
 - ✓ 1,736,008 service visits by facilities or CHWs
- ✓ 99.6% of annual target met for decreasing the prevalence of anemia

SSQH-CS ensures the delivery of health services in USAID-supported networks and scales up access and use of MSPP's essential package of services at facility and community levels. The project supports the delivery of services at 80 sites and their surrounding communities. Grounded in the continuum of care from the community to facility level, the project brings essential services to the lowest possible levels

while improving the quality of services along the continuum. Focused technical assistance targets the improvement of service quality and integration, and support for CHW broadens the delivery of services at community levels. Mobilization and support of community groups work to increase demand for and use of these improved services. Finally, the project

acknowledges the efforts and good work carried out by the health sector personnel at the 80 participating service delivery sites, which managed a transition from the previous USAID-funded SDSH II project to SSQH-CS seamlessly, and played a pivotal role in the SSQH-CS's performance.

Each technical area in this section includes a summary table highlighting indicator performances. A full Indicator Summary Table for all project indicators is found in Annex A.



Figure 1: SSQH-CS supported facilities [data source: SSQH-CS Site Database]

HIV/AIDS

HIV/AIDS Indicator Performance Summary Table	
Met 90-110% of target (N = 3)	% of adults and children known to be alive and on treatment 12 months after initiation of ART (71.0% or 92.2% of target) – O1.HIV20
	% of HIV service delivery points supported by PEPFAR that are directly providing integrated FP services (100% or 100% of target) – O1.HIV27
	No. of PEPFAR-supported testing facilities with capacity to perform clinical laboratory tests (24 or 100.0%) – O1.HIV31
Exceeded target > 110% (N = 7)	No. pregnant women with known HIV status (46,754 or 116.9% of target) – O1.HIV01
	% of pregnant women with known HIV status (94.5% or 174.9% of target) – O1.HIV01a
	No. of individuals who received testing and counseling services for HIV and received their results (167,202 or 133.8% of target) – O1.HIV10
	No. of HIV+ adults and children receiving a minimum of one clinical service (6,992 or 129.5% of target) – O1.HIV11
	No. of adults and children currently receiving ART (3,824 or 139.8% of target) – O1.HIV19
	No. of HIV positive adults and children who received at least of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load (6,992 or 129.5% of target) – O1.HIV25
	No. of HIV-infected adults and children newly enrolled in clinical care during the reporting period that received at least one of the following at enrollment: clinical assessment (WHO staging) or CD4 count or viral load (2,406 or 143.1% of target) – O1.HIV29
Below < 90% of target (N = 8)	% of HIV+ pregnant women who received antiretrovirals to reduce rise of MTCT during pregnancy and delivery (75.3% or 81.0% of target) – O1.HIV03
	% of HIV+ patients who were screened for TB in HIV care or treatment setting (45.2% or 50.3% of target) – O1.HIV14
	% of infants born to HIV+ women that receive a virological HIV test within 12 months of birth (52.7% or 58.5% of target) – O1.HIV16
	No. of adults and children newly enrolled on ART (1,443 or 60.6% of target) – O1.HIV18
	No. of HIV+ adults and children receiving care and support services outside the health facility (1,441 or 29.0% of target) – O1.HIV20a
	% of registered new and relapsed TB cases with documented HIV status (73.7% or 76.8% of target) – O1.HIV23
	% of HIV+ new and relapsed registered TB cases on ART during TB treatment (67.7% or 75.2% of target) – O1.HIV23a
	No. of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV (5,440 or 77.7% of target) – O1.HIV26
Indicator revised (N = 2)	% of HIV+ patients in HIV care treatment (pre-ART or ART) who started TB treatment (95.2% or 100% of target*) – O1.HIV15 – issue with indicator definition includes HIV+ patients diagnosed with TB, not total no. of HIV+ patients receiving minimum one clinical service
	% PLHIV in HIV clinical care screened for TB symptoms at the last clinical visit (O1.HIV32) – Indicator revised data source to measure HIV+ patients screened for TB and not diagnosed with TB.

Table 1: HIV/AIDS Indicator Summary Table

Overview of HIV-related indicator results

PY2 ended with strong achievement results for: pregnant women with known HIV status (up 41 percentage points from PY1); percent of pregnant women with known HIV status (+100 percentage points); HIV+ adults and children currently on ART (+50 percentage points); HIV+ adults and children newly enrolled in clinical care and received clinical assessment, CD4 count, or viral load at time of

enrollment (+30 percentage points); and number of persons receiving HTC and test results (+10 percentage points).

The indicators with steady results since PY1 include number of HIV sites providing integrated family planning services (all sites offer FP with the exception of two sites run by Catholic groups); and number of facilities with capacity to perform clinical lab tests.

Key areas where the project needs to improve its performance for PY3 are closing the gap between when clients find their HIV seropositive status and when they begin ART treatment, improving follow-up support at the community level for HIV clients and encouraging them to return to the clinic for care, and increasing capacities of TB providers to test for HIV. The project's PY3 strategy to implement "test and treat" at facilities in PY3 will help the project shorten the time between when clients receive their positive status and when they begin treatment, and will help improve performance in newly enrolled ART cases. Support for improving counseling capacities of providers to show the evidence-based benefits of immediate enrollment into treatment will also help to encourage pre-ART clients to start treatment immediately. Intensified community outreach through ASCP engagement and mobilization efforts will help with client follow-up challenges and encourage clients to return to the clinic (with infants in the case of HIV+ women who deliver) for services. Finally, mentoring support to improve capacities of TB providers to test for HIV will help co-infection performance, with strengthening referrals between TB Dx/Tx and ART facilities will enable HIV+ TB cases to start ART sooner.

The MESI results for the indicator "percent of registered new and relapsed TB cases that are HIV+" declined between Y1 and Y2, yet an internal analysis of facility registers suggests that the project is actually performing higher than MESI statistics indicate. The project will work with site staffers to improve reporting of TB patients with documented HIV status. Similarly for the indicator "number of active beneficiaries served by PEPFAR OVC programs," SSQH-CS will work with sites that offer programs for OVCs to ensure that facility personnel know to record the number of beneficiaries of all services - psycho-social and clinical - since anecdotal evidence suggests that clinical services received by OVCs and their families are not always recorded.

HIV/AIDS Activities

SSQH-CS continued its support to PEPFAR-funded facilities for the delivery of HIV testing and counseling (HTC), palliative care, ART, PMTCT, OVC, and TB services. By the end of September 2015, the SSQH-CS network included 24 sites offering HTC, 21 with palliative care, 16 with ART, 22 with PMTCT, and 22 serving OVCs. This year, the project upgraded one facility, CSL Aurore du Bel-Air, to provide ART. SSQH-CS agreed to support PMTCT and early infant diagnosis (EID) services at Lucelia Bontemps when CDC PEPFAR funding ceased at this site. The project rolled out an intensive HIV community strategy during the second half of the year. This entailed training of ASCPs¹ in HIV, service referral, tracking of lost to follow-up patients (LTFU), and use of mSanté to provide care and support.

SSQH-CS collaborative efforts with the Caris Foundation, SCMS and Haiti's National Lab led to improved quality of HIV care through on-site lab capacity-building, networking and increased staff mentoring visits. Strong leadership at the MSPP central level resulted in the clarification of national priorities and policy in regard to reinforced service integration. A seminal announcement by MSPP in early March

¹ ASCP refers to those CHWs who have completed the MSPP five-module training. SSQH-CS supports both CHWs and ASCPs. CommCare mSanté trainings target ASCPs.

2015 mandated that all service providers, regardless of specializations, take responsibility for delivering HIV services².

Following meetings with the USAID/Haiti team at the beginning of last semester, SSQH-CS developed and implemented a strategic and operational plan to boost HIV results by the end of PY2. Based on the results of an internal performance review in August 2015, SSQH further revised the plan. SSQH management reallocated funds within the project in order to support intensified HIV activities (mentoring, CHW work, job-aids, etc.).

SSQH-CS worked with service delivery partners to reorganize the referral network between main institutions and feeder sites. Priority sites were identified based on potential and capacity to enroll more patients. Smaller sites were designated as feeder sites for making referrals to the larger high-capacity institutions. Sites with good potential of HIV were benefited from SSQH-CS mentoring that promoted same day treatment and testing.

HIV partners (GHESKIO, PIH, CDC partners) within the CD4 networks collaborated closely to improve (reduce) response time for getting test results. HIV advisors devoted a large percent of their time to reinforcing four SSQH-CS high potential sites (Finca, ICC Grace, FONDEFH Delmas 75 and Martissant. Advisors also helped all SSQH HIV service delivery partners to plan and carry out targeted HIV testing and to improve regular screening of patients for ART eligibility and care retention.

SSQH-CS institutions faced many obstacles to delivering high-quality care. Challenges included insufficient staffing, unreliable internet access and electricity service, poor leadership and management issues at some ZC sites, and general insecurity and violence in some areas such as Cite Soleil. There was little or no support for intensified HIV service efforts from some DDS. Some did not want to reduce services at sites that did not perform well. SSQH-CS advisors had to continue to monitor the poor performers, thus reducing the time available for high potential sites.

Other challenges emerged from PEPFAR's evolving funding priorities and criteria. In mid-PY2, PEPFAR informed partners that in order to continue to receive funds for scale up of ART activities, facilities must serve a minimum number of HIV patients per year. For facilities not meeting the minimum number of patients, HIV services would have to be maintained at current levels, reduced or discontinued altogether. This was unwelcome news for some of the SSQH-CS sites. Nonetheless, the project and service delivery partners rose to the occasion and made plans to strengthen the referral system between sites as well as to further improve the capacity of high-volume sites to provide good quality services to newly referred clients.

ART Services

Specific activities undertaken during PY2 targeted quality improvement of ART services at 16 sites. Service upgrade efforts focused on resuming ART service at Bel Air and keeping PMTCT at Lucelia Bontemps. Regular mentoring and coaching visits by SSQH-CS advisors continued to strengthen health provider capacities in ART and PMTCT reporting, the proper use and maintenance of patient files (for improved adherence monitoring), palliative care, laboratory chemistry and management, and commodity management. On-site technical assistance also supported HIV integration with FP, MH, and GBV services, while off-site trainings provided focused, in-depth HIV/TB instruction to selected staff. A

²"Note Circulaire aux Hôpitaux Universitaires, aux Hôpitaux Départementaux et Hôpitaux Communautaires de référence," MSPP, March 5, 2015.

mobile mentorship team comprised of a medical doctor, a nurse, a laboratory technician, and project coordinator conducted mentoring visits at priority HIV sites. Coaching sessions for providers at FOSREF MARP and youth centers within project-supported catchment areas helped to improve HTC and youth-friendly HIV services while strengthening referrals for key populations to project-supported ART sites.

At the community level, the project continued its training of ASCPs to build community awareness and referral for HIV services, and began piloting the mSanté HIV application, specifically designed for Haiti, at two high-volume service sites (ICC and CS Delmas 75) to further support this effort. The mSanté application guides ASCPs through prevention and treatment support at the household level. The rollout of this module across SSQH sites will be done in PY3.

During PY2, the project also developed a community “accompagnateur” model and operational plan to augment retention and adherence to care and treatment rates and address cases of LTFU. The model calls for PLHIV to act as accompanists for newly enrolled patients (ART and when appropriate, DOTS). It also provided for the training of ASCPs to monitor, in an appropriate and sensitive manner, HIV patients in the community and encouraged social support groups to play valuable roles in the strategy. Training of ASCPs in this community care model continued in earnest during the last quarter.

It became apparent by PY2 that there was a need to ensure use of a standard definition for LTFU across the SSQH network to facilitate accurate reporting by providers. SSQH advisors noted that some providers were counting patients as LTFU when in reality the patients either had sought services elsewhere or had died. To address the issue, during PY2 the project standardized and clarified the definition of LTFU across SSQH-CS sites.

HIV/TB Co-Infection

To address cases of HIV/TB co-infection, the project worked with sites to routinize the HIV screening of all TB patients. Seventy-five percent of SSQH-CS-supported sites offering HIV services also include TB screening and treatment services (18 of 24), and one additional site (Bel Air) offers treatment exclusively. This alignment of HIV and TB services has facilitated the management of co-infection.

During the reporting period, the project mentored health providers at seven ART sites³ to address co-infection through screening of TB patients for HIV and vice versa. Results in MESI show 1,370 TB patients were tested for HIV. During TA visits project advisors reviewed site procurement plans for rapid testing supplies and coached providers on national TB care guidelines. SSQH-CS worked at both DDS and site levels to promote a team approach between HIV and TB specialists to fully integrate HIV/TB wherever possible. The team approach involved regular meetings to discuss service delivery issues concerning the provision of TB care at HIV clinics and vice versa.

Nonetheless, reporting still remains a challenge. I-Santé (the reporting tool for HIV and TB) doesn’t directly report TB screenings, but it does have a TB screening section that shows if a patient has been asked 5 key TB screening questions. SSQH-CS continues to work with i-Tech, Solutions, and METH, to address the issue of complete and accurate reporting of TB data.

While a majority of ART sites also have TB diagnostic and treatment capacities, a few sites do not. In such cases, the site has to refer clients to TB sites outside of the network. During PY2 TA to these ART sites focused on strengthening referrals between institutions.

³ CSL Abricots, CAL Les Anglais, HCR ICC Grace, CAL AEADMA, CAL Matheux, CAL Martissant, and CSL Maissade.

While less and less emphasis is placed on laboratory support under PEPFAR, the project nonetheless provided coordination among national bodies such as the PNLS and the National Lab, USG partners such as SCMS, the DDS and individual facilities to strengthen lab capacity and maximize resources. In Nippes, SSQH-CS advised the PNLS on selection of a site for allocation of a PIMA CD4 machine. CAL Dame Marie was chosen, received the machine from SCMS, and clinical personnel were trained in its use by technicians from the National Lab. The project also helped other facilities to obtain equipment. CS Delmas 75 received a reflotron analyzer, OBCG received a spectrophotometer, and facility staff received training in use of the equipment. And, a PIMA machine was set up at ICC facility.

PMTCT Services

PMTCT services are offered at 22 project-supported sites, including most recently at Lucelia Bontemps, which had ceased services in April 2015 when its CDC PEPFAR funding ended. The sites received supportive supervision and mentoring visits from SSQH-CS advisors covering MESI access and data reporting, patient file maintenance and usage, and commodity management. ANC nurses received mentoring on HTC and PMTCT service delivery, including instructions on counseling and patient flow management.

Other HIV clinical care services

Broader support and care for HIV+ adults and children include psycho-social, legal, and educational services. The project continued its collaboration with the USAID/BEST project, implemented by Caris Foundation, to broaden OVC services at SSQH-CS sites. This collaboration strengthened provider capacities in early infant diagnosis (EID), PMTCT, pediatric HIV, data collection, lab support, and pediatric treatment protocols. Additional services supported by the collaborative effort included school enrollment for OVC, vocational training, household economic strengthening activities, and provision of medical and non-medical supplies (e.g., antiparasitics, paracetamol, and mosquito nets). The HIV strategy for community engagement targeted community support groups for PLHIV and OVCs to help increase their access to psycho-social care.

HIV Next Steps

Going forward into PY3, SSQH will support targeted and client-centered integrated care. The care model envisions that 60% of care and support will be provided in the community and 40% at the health institution level, the latter mostly for routine lab follow-up, complete physical exams and emergency care. SSQH-CS advisors will intensify assistance to improve timely and accurate reporting at the facility level. Project management will discuss with USAID M&E experts to resolve definitional issues noted in regard to a few indicators. Active participation of polyvalent community health care workers (ASPCs) will strengthen community participation in HIV activities, promote understanding of HIV and its impact on families and communities, and reduce discrimination and stigma. Referrals and follow up are expected to increase due to the wider use of mSanté in PY3.

TUBERCULOSIS

TB Indicator Performance Summary Table	
Exceeded 110% of target (N = 2)	Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population (128 or 141.6% of target) – O1.TB01
	% of estimated new smear-positive pulmonary TB cases that were detected under DOTS (75.5% or 140.4% of target) – O1.TB01
Below 90% of target (N = 2)	% of project-supported facilities adopting and implementing an infection control plan (42.5% or 70.8% of target) – O1.TB03
	% of PLHIV newly enrolled in HIV clinical care who started IPT (83.8% or 88.2% of target) – O1.TB04

Table 2: TB Indicator Summary Table

Overview of TB Indicator Results

Strong gains in TB case detection and notification during the year resulted from increased project support in TB technical assistance and improved links between facilities and the national lab. SSQH-CS added an advisor to augment its mentoring support at TB facilities, and coordination with the national lab and SCMS helped the provision of lab equipment at key facilities. These inputs contributed to the project exceeding targets for case notification rates and percentage of new cases detected under DOTS (141% and 140% respectively). This momentum will continue in PY3: ongoing mentoring support will continue to strengthen HIV/TB service integration, while focus on strengthening referral system between TB facilities and communities will help ensure suspected TB cases are identified and positive cases enrolled on treatment. Yet despite these gains, the project did not meet its targets in the number of sites implementing infection control plans and the percentage of PLHIV newly enrolled in HIV care who start isoniazid preventive therapy (IPT). PY2 saw an increase of facilities implementing an infection control plan from PY1, from 26 to 34, and ongoing TB and WASH coordination in PY3 will support the expansion of sites with infection plans. However, the PY3 target of 100% facilities implementing infection control plans is very ambitious given the work required to put plans in place (including supplies needed to implement plans). PY3 strategies to improve rates of HIV clients returning to clinics for care, including aggressive community mobilization, will help the project increase the number of PLHIV enrolled in HIV care to start IPT as appropriate.

TB Diagnostic and Treatment Services

In coordination with the DDS, facilities, and community-based services, SSQH-CS supported the intensified case identification, notification, and treatment of TB patients. Working at the departmental level, project advisors conducted joint meetings to help define strategies and plans for linking HIV resources to support TB services and to identify diagnostic equipment needs. Eighteen (18) project-supported sites have the capacity for diagnostic services while 19 can provide treatment (treatment sites include the 18 diagnostic sites). Coordination with the DDS reinforced the availability of TB protocols at sites, while mentoring visits supported their use.

Equipment and supply shortages hindered some sites' ability to adhere to protocols and limited diagnostic capabilities. The project coordinated with SCMS and MSPP institutions for equipment needs, but demand often surpassed supply. To address this, SSQH-CS included select equipment to support TB services on the procurement plan submitted to USAID in August 2015. Procurement will be done by the USAID/LMG project on behalf of SSQH-CS in the coming year.

Site level TA focused on addressing co-infection to reinforce TB screening for HIV patients and the enrollment in treatment of those testing positive. SSQH-CS advisors worked with HIV care providers on

the provision of IPT and coordinated with SCMS to ensure IPT availability at HIV/TB sites. By the end of PY2, the project had reached 88.2% of its annual target for patients receiving IPT. Related ASCP trainings covered community outreach, active case identification strategies, and instructions for making appropriate referrals for diagnosis and treatment.

TB Infection Control

The project worked with facilities to adopt infection control plans through mentoring visits and remote support. By the end of PY2, 34 facilities had an infection control plan. Project advisors assessed existing plans and provided feedback for improvement as warranted. At some health centers, advisors co-designed plans on site with providers. To this end, the project developed an infection control plan template to help PEPFAR facilities develop their respective plans. The template covers multiple aspects of implementing infection control, including management committees, staff training needs, monitoring and reporting, and environmental considerations. However, even with plans in place, adherence can sometimes be problematic. Some facilities experienced stock outs of basic infection prevention supplies such as masks and gloves. Despite the project's efforts to coordinate with the DDS and SCMS to respond and provide supplies, a few sites periodically faced shortages or stock outs.

TB Next Steps

SSQH-CS recognizes that more work needs to be done to address HIV/TB co-infection. Selected activities prioritized for PY3 include ongoing health provider trainings in HIV/TB co-infection care and case management, and ASCP trainings in community case detection and referrals. Support for facilities is envisioned for printing of posters/job aids (e.g., promoting use of IPT), mentoring providers in developing and implementing infection control plans, and training of personnel in national guidelines and protocols, and waste management. Community mobilization and outreach by ASCPs will help in the follow-up of HIV patients and encourage suspected TB cases to return to the clinic for diagnosis and treatment.

MATERNAL AND CHILD HEALTH

MCH Indicator Performance Summary Table	
Met, 90% - 110% Target (N = 6)	% of women who received at least 3 ANC visits during pregnancy (44.3% or 95.3% of target) – O1.MCH01
	Prevalence of anemia among pregnant women (11.3% or 99.6% of target) – O1.MCH03
	No. of children <5 reached by nutrition programs (393,383 or 93.2% of target) – O1.MCH09
	% of underweight children <5 years of age (0.7% or 105.5% of target) – O1.MCH12
	No. of people trained in CH and nutrition through USG-supported programs (580 or 90.8% of target); O1.MCH14
	No. of women reached with exclusive breastfeeding messages (56,097 or 98.1% of target); O1.MCH15
Exceeded, >110% of Target (N=2)	% of postpartum/newborn visits within 3 days of birth (60.0% or 146.4% of target) – O1.MCH04
	No. of children who received DPT3 vaccine by 12 months of age (37,850 or 114.9% of target); O1.MCH08a
Below, < 90% of Target (N=7)	% of women who received 3+ ANC visits during pregnancy (40.3% or 89.4% of target) – O1.MCH01a
	% of births attended by a skilled doctor, nurse, or midwife (15.6% or 86.7% of target); O1.MCH02
	Prevalence of exclusive breastfeeding of children under 6 months of age (53.7% or 89.5% of target) – O1.MCH06
	% of children aged <1 that are fully vaccinated in project catchment areas (45.3% or 47.7% of target); O1.MCH07
	No. of children <5 who received Vitamin A from USG-supported programs (129,479 or 74.4% of target) – O1.MCH10
	No. of individuals trained to implement improved sanitation methods (186 or 52.8% of target); O1.MCH13
	No. of newborn infants receiving antibiotic treatment for infection through USG-supported programs (550 or 24.4% of target) – O1.MCH16
Problem with Indicator (N=1)	% of children who received DPT3 vaccine by 12 months of age (49.2% or 82.0% of target – comparison with MCH08a shows targets are not consistent); O1.MCH08b

Table 3: MCH Indicator Summary Table

Overview of MCH Indicator Results

Maternal health indicators linked to antenatal care performed very well and mostly met their annual targets. This includes the percent of women receiving at least 3 ANC visits during pregnancy, number of women reached with exclusive breastfeeding messages, and the prevalence of anemia among pregnant women. The project's efforts to encourage and support antenatal care through improved care at the facility and persistent follow-up at the community level were successful. Indeed, the project posted increases from PY1 to PY2 in the number of women who receive at least 3 ANC visits: 32,046 and 35,305 women respectively. Related to this increase is the prevention of and timely response to anemia in pregnant women, as ensured during ANC visits. Accordingly, SSHQH-CS met its expected result for reducing the prevalence of anemia. For post-partum visits, the project surpassed expected results, with 37,028 women having visits within 3 days of delivery. This is an increase by over 10,000 visits from PY1 results. These trends illustrate the project's impact: more women are accessing more MNH services as a result of project support in the areas of intensified MNH support at the community levels through ASCP home visits and rally posts, and improving quality of service at facilities as a result of mentoring visits and trainings support these trends.

Where the project needs to intensify its efforts to recapture expected results pertain to stock management and logistics, such as with vaccines and vitamin A, and the number of births attended by a skilled birth attendant. Stock-outs during periods of the year in CH supplements affected performance in full vaccination and vitamin A indicators. While there does not appear that DPT3 stocks were problematic, as our achievement in the number of children who received DPT3 vaccine shows (114.9% of target), availability of specific vaccines throughout the year was not consistent and affected performance in full vaccination rates. Another area requiring project support is to increase the number of skilled birth attendants. Many health posts are not staffed with doctors or midwives, but only have auxiliary nurses who may have experience delivering but not have formal training on a range of situations that can occur during birth. As such, the project was not able to reach its target on the number of births attended by a skilled birth attendant. However, SSQH-CS is in coordination with the Maternal Child Survival Program (MCSP) to provide intensive trainings for providers in delivery and other areas during PY3, which will increase the number of skilled birth attendants operating in project networks and boost performance in this indicator.

Finally, availability of timely data for selected indicators presented obstacles for the project to fully report. External studies managed by the project to collect data for the prevalence of exclusive breastfeeding and the number of newborn infants receiving antibiotic treatment reported data for only 23 sites, posting an achievement rate of 24.4% of the target. Improved reporting samples next year will provide more representative data from the supported sites catchment areas.

Maternal and Neonatal Health

SSQH-CS continued its support for basic MNH care at community and institutional levels through service delivery financing, provider trainings, technical assistance, home visit support, and basic equipment provision. During the year, doctors, nurses, and auxiliary nurses from fifty-nine (59) sites benefited from coaching and mentoring visits from project advisors. These visits reinforced the use of national protocols in ANC, safe delivery, post-partum, and essential newborn care. With many of the facility providers also staffing the mobile clinics, this technical assistance also supported community-based care. Other TA highlights for the year include 26 providers trained in safe delivery (n=20) and PAC (n=6)-in the Grand Anse and Nippes respectively.

Site visits also allowed project personnel to assess equipment and supply needs at facilities. The project distributed 36 delivery/obstetric tables to 30 sites during Y2. Priority was given to sites that either had no tables at all or had ones in disrepair. The project still has a few delivery tables to distribute in Y3. Other equipment needs identified includes sphygmomanometers, stethoscopes, and other light equipment, particularly to support mobile clinic operation. These items will be procured and distributed in PY3.

Year 2 laid critical groundwork for increasing training opportunities for SSQH-CS providers through close collaboration with the MCSP. Evaluation of provider training needs has informed the development of plans to target SSQH-CS providers to train them in birth preparedness, early danger signs in pregnancy, safe delivery, post-partum care, and essential newborn care. These trainings will start in PY3 and the project will support providers to attend in collaboration with MCSP.

At the community level, a total of 429 ASCPs (received training to recognize and identify danger signs of pregnancy and anemia, promote the importance of breastfeeding and iron and folic acid supplementation, and to refer cases via MCH networks as appropriate, as per the MSPP curriculum. ASCPs provide basic yet essential MNH services through home visits and rally posts, identifying pregnant

women and encouraging them to attend ANC visits. ASCPs trained and supported to use CommCare accessed job aides to facilitate MNH consultations. During the period, ASCPs using CommCare made 719 referrals related to prenatal danger signs and 224 referrals for postnatal danger signs.

Child Health and Nutrition

During PY2, site-level technical assistance at 59 facilities strengthened provider capacities to monitor and promote child health and nutrition. Evaluations surveyed tools and resources available for vaccination and malnutrition programs, including availability of deworming drugs, syringes, antigens, and vitamin A. TA to facility personnel reviewed and shared best practices for using tools such as vaccination daily journals and inventory management forms. Project advisors worked with site providers and managers on infant and young child feeding best practices and reinforced correct and consistent usage of growth monitoring and reporting tools, including technical forms, national registers and dashboards, activity calendars, and monthly reports.

The project built health provider capacities and supported site stocks to advance nutrition objectives. Six (6) trainings on acute malnutrition, done in coordination with the DDS, provided instruction to 120 facility health providers, covering nutrition concepts and education (i.e. exclusive breastfeeding), malnutrition screening and anthropometric measurements, norms and protocols, mobilization and community participation, and case studies and practical exercises (i.e. effective use of data collection and reporting). For community-based providers, the project trained 429 ASCPs in child health as per the MSPP curriculum. Once providers received training in malnutrition prevention and treatment, project staff worked with facilities to develop distribution plans for RUTF (ready-to-use therapeutic food), and distributed 1,306 boxes of Plumpy Nut to sites. In Y2, SSQH-CS trained 580 individuals in child health and/or nutrition, approximately 90.7% of the annual target. The project also distributed 30,000 vaccination cards to sites.

At the departmental and central levels, the project coordinated with DDS/DSO to support the availability of materials and resources (scales, rulers, and malnutrition registers, etc.) for sites that benefited from trainings. When approximately 50 facilities in the West department experienced stock outs in CH and other vaccines (i.e. measles, mumps, and rubella), SSQH-CS helped identify where in the supply chain blockages were occurring (regional UCS/UAS levels) and coordinated with MSPP to help resolve the dilemma. With the approval of MSPP to implement, SSQH-CS worked with NGOs with strong logistics capacity to transport vaccines from the DPEV level to the regional UCS/UAS level. MSPP allowed project-supported NGOs to receive vaccines for not only their own network sites, but arrange for all other non-network health facilities in their coverage area to order vaccines through their NGO for pick up at the UCS/UAS. In some cases when no NGOs were available for non-network facilities in the area, SSQH-CS delivered products directly to the UCS/UAS on their behalf or directly to the facility site.

Water, Sanitation, and Hygiene

Results from Y1 WASH assessments (n=25) identified sites needing rehabilitation work to improve water and sanitation facilities. Assessment data also mapped training needs in WASH-related content. The project developed a WASH rehabilitation plan for six (6) sites and began the procurement for light work at two sites (Delmas 75 and Martissant).⁴ This procurement was delayed while the project coordinated with USAID as to which project will commission the proposed work. By the end of PY2, it was decided that SSQH-CS would proceed with the renovations at Delmas 75 and Martissant, and share with USAID

⁴ The proposed work at the selected sites include the renovation of toilets, sinks, and proper drainage, as well as providing some cosmetic and minor refinishing work in the existing sanitary block.

the rehabilitation plans and estimated budgets for the remaining sites for implementation by another USG partner. It is expected the work at the aforementioned clinics will be completed in the first half of PY3. This is discussed further in the EMPR section of the report [see Management, Monitoring, and Administration].

Activities to increase health provider knowledge in WASH methodologies and tools use continued during the semester. For the year, the project 62 facility staff and 124 ASCPs were trained in improved sanitation methods. Participants also engaged with the WASH assessment findings from their respective sites, which opened broader discussions about WASH norms and standards. Providers trained in sanitation methods also reviewed WASH assessments for their respective facilities to help them know how the material could be practically applied to their work environments. While the project accelerated the number of providers trained in the second semester, delays in trainings during the first half of the year affected the project's ability to reach its annual target. Improved coordination in PY3 will ensure the project corrects this performance and gets back on track with its expected result.

Community engagement in WASH promotion also saw some solid successes. For Global Hand Washing Day (October 15), the project hosted awareness campaigns at Delmas 75 and Martissant. Project staff promoted basic prevention messages, held demonstrations on hand-washing techniques, and emphasized door-to-door sensitization by CHWs. An estimated 1,500 community members participated in the two events.

At the request of USAID, the project added a new household hand-washing station indicator (O1.MCH16). While SSQH-CS does not have any activities that can clearly and directly be linked to household hand-washing per se, the project may influence such behavior through its WASH promotion and education sessions.

MCH/WASH Next Steps

MNH priority activities for the PY3 include provider trainings in skilled delivery and the continuation of the ASCP/mSanté trainings. A key element for success in this latter activity is the rollout of the CHW supervisor module to engage supervisors in the routine CommCare use by ASCPs. SSQH-CS will also consider the procurement of additional ANC and safe delivery supplies and small equipment. Focus for child health and nutrition activities will be on the continuation of health provider mentoring and trainings, as will the project's continued coordination with health sector partners to address disruptions in vaccine stocks. PY2's underperformance for % of children fully vaccinated underscores the importance of prioritizing community outreach CH activities. For WASH, priorities are the completion of infrastructure improvements identified in the project rehabilitation plan and the increased investment in training ASCPs in WASH content.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

FP/RH Indicator Performance Summary Table	
Met, 90% - 110% of target (N=1)	% of service delivery sites providing FP counseling and/or services (96.3% or 98.2% of target) – O1.FP03
Below, <90% of target (N=3)	Modern method contraceptive prevalence rate (MCPR) (15.3% or 54.6% of target) – O1.FP01
	Couple Years Protection in USG-supported programs (208,046 or 45.2% of target) – O1.FP02
	No. of youth (aged 15 – 25) accessing reproductive health services (50,482 or 66.4% of target) – O1.FP04

Table 4: FP/RH Indicator Summary Table

Overview of FP/RH Indicator Results

For PY2, SSQH-CS ensured that all sites offer FP counseling and/or services, with the exception of three religious institutions, which do not provide FP services as per their mandate. As such, where possible in the network, FP services are available to Haitians in the catchment areas of the project. While the on the supply side the project achieved better results, the demand side and uptake of services presented challenges. Analysis indicates that several factors may influence this under-performance: 1) data appears to be under-reported and MSPP reports only disaggregate by age FP services and deliveries, thereby limiting the available data on RH services for youth; 2) there was no national FP campaign for the year.

While SSQH-CS works with facilities and departments to reinforce the timely submission of reports, performance in MCRP and the number of youth accessing RH services strongly suggests total services are not being accounted for in the data. PY3 will see augmented support to ensure monthly reports are timely and validated to ensure reporting is as complete as possible. The project's analysis of CYP data shows that short-acting methods remain popular, despite SSQH-CS's efforts to increase availability of LARC, such as IUDs (during PY2, SSQH-CS doubled the number of sites trained to provide IUDs to 18). This could be a result of limited knowledge in method mix, but it could also reflect provider bias coupled with myths around LARC for youth and women in general. The project has responded by intensifying community mobilization and ASCP support to generate increased demand for FP methods and by liaising with NGO service providers to support FP service delivery.

Contraception Use and Availability

A central focus for SSQH-CS is to increase access to and use of modern contraception among women of reproductive age. To support this, project interventions included facility- and community-based provider trainings, site-level action planning, departmental coordination and joint supervision, and commodity management. During PY2, 96.3% of project sites (n=77) provided FP counseling and/or services, and 70 have regular FP activities at the community level in their annual workplans. Of these sites, 64 offer at least four contraceptive methods (condoms, pills, injectables, and implants), while 18 sites offer these methods plus IUDs. This last figure represents quite an achievement, as the project increased the number of sites providing IUDs by 100% over the course of the year.

Trainings aimed to build the capacity of providers to offer method mix and make referrals as appropriate. The trainings included DDS technical staff and MSPP/DSF personnel when possible. For the year, 56 providers received training in long-acting and permanent methods (LAPM): six (6) providers in voluntary surgical contraception (VSC), 14 in IUDs, and 36 in implants. As part of the ASCP trainings, 429 received instruction on providing FP and referring clients for LAPMs at facilities, while 50 CHWs received

in-service training on contraceptive methods. The project works with providers to integrate family planning with other services (such as HIV and ANC) and offers training and mentoring in the appropriate provision of mixed methods. Finally, FP cue cards designed to help providers offer complete information on mixed methods were distributed to all 77 FP sites.

However, despite the strong work the project has accomplished to build capacity in contraceptive services, systemic challenges affect data collection/reporting and contraceptive commodity access. Indeed, the project found the CYP rate to be rather low for the year, with only 45.2% of the annual target met (n=208,046). At first glance, this might suggest a poorer performance in contraceptive use. However, a closer examination of the situation reveals a different understanding of this indicator while illuminating major gaps in the health system. The project found during the first semester that 64% of FP sites were not able to post results on DHIS2 and cannot email them to the project. With many sites not having MSPP FP registers either this past year, data reporting is greatly compromised and many FP services that are provided do not find their way into the national HMIS on time. Only NGO facilities tend to have the means to record FP data on notebooks in the absence of FP registers. In terms of commodity availability, IUD stock outs are not a major concern, as MSPP and LMS have committed to ensure their availability across the network. Yet despite the availability of IUDs, not every site with properly trained personnel to deliver the method can do so. Basic medical supplies needed to perform IUD insertions (e.g., Betadine, gauze, gloves, and bleach) are not always on hand, which prevents providers from delivering this service. Limited facility budgets prevent them from purchasing these supplies directly, thus making them dependent on outside sources for their provision. In response to some of these challenges, SSQH-CS worked to procure and distribute FP registers to sites.

National planning and strategy workshops help to increase contraceptive commodity availability and reinforce the integration of FP into other services. Project advisors participated in a MSPP-hosted workshop promoting the national PMTCT strategy, which emphasized the integration of FP services. Coordination with MSPP, LMS, and SCMS supported the availability of contraceptive commodities for sites within the SSQH-CS network. National quantification workshops helped identified site-level FP commodity needs and coordination meetings with SCMS facilitated the provision of needed FP commodities at selected sites.

Youth-Friendly Services

Efforts to increase the number of youth (aged 15 – 25) accessing reproductive health services, including contraception, involved assessments of 18 project-supported facilities to deliver youth-friendly services (YFS). This includes assessing the number and type of providers on site, hours of operation, separate space for serving adolescents. Once YFS capacities were assessed, project advisors developed site-specific TA plans to help improve youth outreach and services offered. Execution of the TA plans started this semester, with project staff providing coaching visits covering HIV/FP/MH and GBV service integration with a focus on youth. A key priority for next year will be to continue working with these facilities to improve their ability to serve adolescents and youth and strengthen linkages between the sites and community outreach groups.

Technical assistance to reinforce the integration of FP services with HIV, maternal health, and GBV services for key populations such as commercial sex workers (CSW) continued. FOSREF has several MARPs and youth centers within the project's catchment area. Onsite mentoring in FP integration at these centers improves services provided while strengthening referrals to SSQH-CS network sites for follow-up care.

USG Compliance

USG Compliance activities continued through the year. Project staff received an annual training in USG legislative and policy requirements for FP. For service delivery partners, technical and managerial staff at all 77 FP sites received compliance trainings, copies of “Tiaht posters” in French, and DVDs with guidelines and monitoring tools. Compliance visits at both clinics and implementing partners’ central offices verified USG compliance files and reviewed content with providers. Monitoring visits showed an understanding of the regulations among site providers, but revealed needed areas for improved documentation and highlighted gaps between some NGO central bureaus and their affiliate service delivery sites. Strengthening the monitoring and technical support relationship between NGO central bureaus/DDS and service delivery sites is a keystone in ensuring compliance across the project network, as the project relies on the former to monitor compliance for their sites. Focus during Y3 will aim to reinforce this link.

FP Next Steps

To help turn around the PY2 underperformance in MCPR and CYP, the project will prioritize key FP/RH activities during Y3, including support for a national FP campaign and ongoing support to facilities in the implementation of plans for offering LAPMs. A major thrust for PY3 will be increased support to improve the timely and accurate reporting of FP services and the capturing of RH services provided to youth. Additional provider trainings in long-acting contraceptive technologies, including IUDs, are critical to ensure clients have access to a full range of methods. Finally, ongoing monitoring and support for FP compliance of USG regulations at service points and partner sites will continue.

GENDER-BASED VIOLENCE AND CHILD PROTECTION

GBV/CP Indicator Performance Summary table	
Met, 90% - 110% of target (N=1)	No. of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other) (113 or 94.2% of target) – O1.GBV01
Exceeded, >110% of target (N=2)	No. of health institutions providing clinical assistance and referrals of child protection cases to legal and social services (36 or 116.1% of target) O1.GBV02
	No. of children reached by child protection services (5,440 or 122.1% of target) O1.GBV03
Below, <90% of target, (N=1)	No. of providers trained to recognize and refer GBV and child protection cases to appropriate legal and social services (186 or 52.8% of target) O1.GBV04

Table 5: GBV/CP Indicator Summary Table

Overview of GBV/CP Indicator Results

Despite some delays experienced during the first half of the year, SSQH-CS made strong pushes during the second semester to either meet or exceed expected results in three of the four GBV/CP indicators. The project reached at least 113 people with GBV services, representing 94.2% of the target. This is no small feat considering the systemic under-reporting of such services in Haiti. SSQH-CS exceeded in reaching 122.1% of its target for the number of children reached by CP services too. These services also tend to be under-reported, and the performance figure represents the number of active OVC beneficiaries served, which is only a subset of those reached by CP services. Unfortunately only OVC data is reliably reported, with other child protection services not routinely documented at sites. The only component indicator that fell short of its annual target was the number of providers trained to recognize and refer GBV and CP cases. While the target was not met, it should be noted that all 186 providers were trained during the second half of the year and shows the project’s efforts to course

correct and ensure the advancement of this indicator. Improved coordination during the semester will continue in PY3 to ensure next year's target is met.

GBV and CP Activities

Facility capacity assessments of GBV services that started in Y1 continued during the first half of Y2. Evaluations verified the availability of GBV services, personnel (including social workers and psychologists), and provided feedback on how to improve services. The project identified 10 priority sites and trained 62 health providers in GBV/CP services (including interviewing techniques) and data collection/reporting. Mentoring and coaching visits at 18 facilities helped integrate and strengthen GBV and youth-friendly services.

In support of community level screening and referrals, the project continued to train ASCPs in GBV and CP during PY2 (a total of 124 ASCPs trained). Training was done in tandem with other SSQH training sessions on WASH and mSanté. The SSQH GBV/CP advisor worked with staff at SSQH-CS sites to sensitize personnel to GBV issues. Many educational sessions on GBV and CP were realized by youth peer educators during the year. FOSREF youth centers within the SSQH-CS catchment area provided GBV referrals to project-supported facilities. Strengthening linkages between youth centers and community groups and project facilities is a continuing priority for PY3.

During PY2 SSQH-CS achieved 156% of the target set for provision of OVC services. Project-supported sites provided services to a total of 5,440 OVC. To achieve this, project advisors collaborated closely with the USAID/BEST project to take advantage of opportunities provided for OVC in SSQH-CS catchment areas. Project advisors provided coaching and mentoring to ensure that staff (providers, psychologists, social workers, etc.) who routinely came into contact with OVC at project sites were fully aware of these opportunities, such as support for schooling, for medical care, for participation in mothers' and children's clubs, and for recreational activities. For the year, 186 facility-based providers and ASCPs received training on child protection, including interview techniques and social work services.

GBV and CP Next Steps

Additional investment for Child Protection, OVC, and GBV activities is envisioned for PY3, funding permitting. This will enable SSQH to address, in collaboration with partners and the proper governmental authorities, lingering judicial, social, psychosocial, and didactic gaps that impact negatively on the status of these target groups. During PY3 SSQH advisors will work with families and the proper governmental authorities to obtain birth certificates for OVCs and other vulnerable persons who need them; facilitate scholarization of siblings of OVCs and other vulnerable children (since Caris assistance is limited to OVCs); provide training and educational materials for health institution staff, mothers' groups and other local associations that assist OVCs and victims of GBV; support recreational activities such as sports and art events for OVCs and their families. With assistance from the project's IMTs, a concerted effort is planned to strengthen clinical services, which offer services for these vulnerable population groups.

CRITICAL CARE

Critical Care Indicator Performance Summary table	
Indicator changed, (N=2)	% of project-supported sites certified to serve as critical care stabilization centers (55.6% or 100% of target) – O1.CC01
	% of sites demonstrating improvement in critical care practices (100% or 100% of target) – O1.CC02

Table 6: Critical Care Indicator Summary Table

Overview of CC Indicator Results

Indicator definitions for basic critical care continue to present challenges for the project due to two key elements: there is currently no national body that can appropriately certify facilities as critical care stabilization centers, and current indicator definitions consider all 80 facilities despite the fact that a majority of the sites are not designed to ever provide such services. Both dispensaries and centers without beds (CSL) do not have the capacity to ever provide basic critical care services and should not be included in either of these component indicators. In an attempt to overcome the gaps listed above, the project considered only referral hospitals (HCRs) and centers with beds (CALs) (n=18) in its calculation of both indicators, as these are the only institutions with the potential capacity to provide critical care services as outlined in the contract.⁵ Of these facilities offering this level of care, 10 or 55.6% provide at least one critical care service. This represents an achievement of 100% of the annual expected result. And of these 10 facilities offering at least one critical care service, project support during the year to improve the quality of these services and to document improvements made helped SSQH-CS attain 100% for O1.CC02. CQI plans established at these sites map how they can make service improvements and supervision visits support the improvement of services and document changes made.

Support for Critical Care Services

SSQH-CS strengthened critical care service provision through provider mentoring, joint supervision, and off-site trainings. CQI plans incorporate steps to improve critical care services, particularly emergency obstetric and acute respiratory management support. A focused training in basic life support and held at Mirebalais benefitted 9 providers from seven SSQH-CS facilities during the year. Content included in the modules covered basic life support, patient stabilization, advanced cardiac life support, pediatric life support, advanced trauma life support, and patient shock management. Continued mSanté support for critical care services during the national Carnival celebrations was disrupted due to an unfortunate accident that resulted in a stampede, which in turn prevented the active and effective deployment of ambulances and resulted in the celebrations being called off early. The crisis underscored some of the vulnerabilities critical care responders face in emergency situations in Haiti.

Critical Care Next Steps

The project will continue its support for improving critical care services at the 10 facilities that currently provide them, and will see what possibilities exist to expand services at the remaining HCRs and CALs. Coordination with MSCP to provide emergency obstetric training to health providers starts in the first quarter of PY3 and will continue throughout the year.

⁵ Critical Care services include acute cardiac management; acute trauma management; acute stroke management; acute respiratory management; acute orthopedic management; disaster preparedness; pregnancy complications including unplanned Cesarean sections; and basic life support.

COMMUNITY-BASED ACTIVITIES

Community-Based Activities Indicator Performance Summary table	
Met 90% - 110% of Target, (N=2)	Total no. of clients accessing services provided by project-supported facilities or CHWs (1,736,008 or 95.3% of target) O1.CB04
	% of health referral networks with UAS coordinator supervisory visit documenting QI in last 6 months (100% or 100% of target) O1.CB06
Exceeded, > 110% of Target, (N=1)	No. of service providers trained who serve vulnerable groups (84 or 112.% of target) O1.CB02
Below, < 90% of Target, (N=1)	No. of sites providing care and support for vulnerable groups (15 or 65.2% of target) O1.CB01
Other, (N=2)	No. of communities establishing an emergency transportation system for pregnant women within the reporting period (100%) O1.CC06 – changed indicator definition
	No. of households with soap and water at hand washing station commonly used by family members (379/819) – O1.CB07

Table 7: CBA Indicator Summary Table

Overview of CBA Indicator Results

Impressive gains during the year were made in the total number of visits provided at project-supported facilities or CHWs. Results show that the project maintained the total number of visits from PY1 to PY2 (1,734,446 and 1,736,008 respectively). Other successes were the number of providers trained to serve vulnerable groups (n = 84), which includes OVC care within the comprehensive HIV training sessions. Finally, efforts to support health referral networks (which includes HCRs and CALs) to have UAS/DDS supervisory visits documenting quality improvement within the last 6 months have produced substantial results, with 100% of the 18 referral network facilities complying.

Progress in other indicators was tempered by either challenge with indicator definition or with data collection delays. While there exists communities with established transportation systems that enable pregnant women and other emergency cases to access facility services, most do not meet all the criteria established in the indicator definition.⁶ However, project advisors note that these communities often have at least three of the requirements and function successfully. With this consideration, SSQH-CS identified 10 communities, primarily in the greater Jeremie region, that have successful emergency transportation systems in place.

Community Engagement

During PY2, SSQH-CS honed its community mobilization strategy that espouses self-reliance and active participation of communities in the identification and resolution of perceived community health priorities.⁷ The identification process is a dynamic one and may vary from community to community, and from year to year. That is why the SSQH-CS community health strategy underscores the importance of setting up permanent mechanisms such as community health committees at the community level to assess needs on a regular on-going basis.

⁶ The community must have a written plan clearly outlining where, how and by whom the emergency transport will be provided; There must be a formal MOU established with the local health center and/or hospital and the USG implementing partner for referrals; The transportation system must be accessible to all pregnant women; There must be a registry for documenting requests for service and use of services; The system must have been used at least once since the last reporting period; The USG implementing partner must have assisted the community to develop and establish the emergency transportation system

Moreover, the project successfully used the Pathway to Change (P2C) tool and methodology⁸ to inform the strategy. During the year, the project engaged providers at ZCs. The results from the P2C exercises led to the development, in collaboration with MSPP counterparts, of specific counseling messages for key health behaviors, barriers and facilitators. By the end of PY2, plans were underway to make professional recordings of the messages. The recordings will be included in the mSanté curricula in PY3.

Priority foci services initially identified by SSQH communities included: Maternal and Child Health; Child Protection and Gender-Based Violence; STIs/HIV/SIDA; and Family Planning. The SSQH Community Mobilization Strategy was incorporated into and is reflected in the project's overall HIV strategy which harnesses and builds upon home visits, community support groups (i.e. *clubs des meres*, *youth groups*), mSanté, psychosocial services, and peer accompaniment to reinforce and promote service delivery.

Community-based Services

During PY2, the support for community-based services continued through service delivery agreements (NGOs and ZCs) and ASCP trainings. A total of 429 CHWs completed the MSPP ASPC modular course, and 75 field agents completed HIV training that focused on community education and follow-up of PLHIV at the community level. In addition, 68 ASPC supervisors responsible for implementation of community health activities participated in training designed to build capacity in mentoring, supervision and management of CHWs in the SSQH-CS network. Decentralization of services to the lowest possible level occurred through facility-led mobile clinics and community health agents, who conducted home visits, organized rally posts, and referred clients to service delivery sites in the project catchment areas. Technical assistance to CHW supervisors was reinforced by the expansion of the mSanté program to include a CHW supervisor module that was used in formal training sessions. The mSanté program further helped to improve the quality of data collection at the community level and linked results to referral facilities.

Community-based Activities Next Steps

During PY3, the project will assist ZC facilities with the organization of mobile clinics to deliver a variety of services, including FP, MCH, HIV testing, and behavior change activities. SSQH-CS will also provide financial and technical support for the implementation of 25 community mobilization plans at HIV saturation sites and other select sites. Additional ASCP trainings, including training in mSanté, will arm more CHWs with the knowledge, skills, and tools to deliver services through home visits and rally posts. Engagement of CHW supervisors, particularly through mSanté, should increase referrals between CHWs and facilities, and help to ensure that the quality of care delivered at the community level is high. Also important will be the mentoring of supervisors, CHWs and data managers at SSQH facilities in the use of the M&E dashboard and indicators and the ongoing monitoring of health services at the community level to ensure results are accurate, timely, and make their way to the national HMIS.

⁸ P2C is a board game designed by Pathfinder International to engage community members to identify facilitators and barriers to service access and use. SSQH-CS has oriented MSPP and individual DDS on the use of P2C and has incorporated the tool in ASCP trainings. The MSPP has even adapted the tool for its own use.

OBJECTIVE 2

IMPROVE THE FUNCTIONALITY OF THE USG-SUPPORTED HEALTH REFERRAL NETWORKS

Semester Highlights:

- ✓ 91.2% of Y2 target achieved for number of CHWs active in project health referral network
- ✓ 270% increase in regular CommCare use among ASCPs after supervisor module launched
 - ✓ 18 sites networked to use PIMA CD4 diagnostics

SUPPORT FOR CHWs

SSQH-CS ongoing assistance for CHWs covered payment of salaries, supplies, supervision, and training costs. SSQH-CS coordinates with linked NGO and ZC service delivery partners to identify and train CHWs and their supervisors in the national MSPP ASCP curricula modules. During PY2 a total of 429 CHWs completed the MSPP ASCP modular courses earning them the right to official certification as *agent de santé polyvalent* or ASPC. A total of 68 ASPC supervisors from the SSQH-CS network



Figure 2: ASCP provides a consultation during a rally post

also received advanced training in mentoring, supervision and management of ASCPs. And, as part of SSQH-CS's HIV services boost strategy, 75 field agents⁹ received refresher training in HIV including stigma reduction, effective referrals, identification and follow up of PLHIV at the community level.

Building off the foundation laid by an earlier USAID project, SDSH II, which trained CHWs in three of the official five-module MSPP CHW curricula, SSQH-CS trains participants in two modules. It should also be noted that in addition to the training in the national modules, most of the CHWs also benefitted from supplementary training in WASH, GBV/CP and mSanté.

By the end of PY2, 904 CHWs had completed the MSPP curricula and had qualified for ASCP certification. This represents over 90% of the SSQH-CS life-of-project LOP objective to train 1,000 CHWs. During the reporting period SSQH-CS coordinated with MSPP authorities to plan ASPC certification ceremonies in

⁹ The title of field agent was coined by CDC PEPFAR to designate CHWs that focus exclusively on community health HIV services.

different departments. Two such ceremonies are scheduled to take place during the first quarter of PY3. CHWs will receive certificates, official ASPC identification cards and badges, ASPC shirts and caps, and other accoutrements including rain poncho, flashlight, and backpack procured by the project.

CHWs Next Steps

An additional 96 CHWs will be trained during PY3¹⁰ SSQH-CS in all 5 MSPP ASPC modules.

A total of 240 field agents will be trained in HIV community health, identifying LTFU and OVC and referring them for appropriate care and services. Ceremonies will be held in the departments to provide ASPC certificates and support materials to CHWs who completed the required MSPP curricula.

Mobile Health - The SSQH-CS mSanté Program

During PY2 SSQH-CS further developed and trained ASCPs in the mSanté mobile suite of tools despite delays in the approval process for renewing the subcontract with CommCare¹¹ developer Dimagi. The mSanté MCH and FP modules were built and used by ASCPs in PY1. A corresponding module was subsequently designed for ASPC supervisors and rolled out in early PY2. It enabled oversight of ASPC work and real time case management dialogue between ASCPs and supervisors. It also served as a vehicle for ASCPs to give institution-based providers advance notice of patients being referred for services.

The SSQH-CS mSanté activity is a flexible program that evolves and adapts readily to actual needs and realities on the ground. In the first half of PY2, mSanté advisors provided ongoing technical assistance to the ASCPs who had been trained in mSanté during Y1 (N=309). Advisors monitored usage and provided remote and in-person trouble-shooting help. Despite these efforts, the project noticed that only about 20 percent of ASCPs trained to use mSanté were actively doing so, while for the majority of ASCPs usage was sporadic.

Project advisors quickly determined that the ASPC supervisors were key links for supporting ASCPs and therefore for reinforcing use of mSanté. The project subsequently fast-tracked the design of an mSanté module for supervisors and trained 34 supervisors in its use at Fermathe and FONDFEFH sites in the West Department. Once supervisors began using mSanté and knew how to support use of mSanté by CHWs the number of ASPC active users increased significantly.

SSQH-CS initially intended to use mobile phones for the mSanté program, but early on switched from using phones and opted instead to procure electronic tablets, which were made locally. In early PY2 SSQH-CS received direct funding from another USAID project, HIFIVE, to procure additional tablets. The tablets were received by the project in February/March 2015 and were distributed to ASCPs who completed the three-day mSanté training.¹² SSQH-CS mSanté advisors monitored CHW usage of the tablets closely. And, by mid-PY2, advisors strongly recommended that the project transition from the use of tablets to mobile phones. Wide field experience had demonstrated that the tablets had a short lifespan (various problems were encountered with nearly 30% of the tablets: problems with the ports, screens shattered too easily, cumbersome to carry). Mobile phones were simply more practical -- small

¹⁰ By the end of PY2, training plans for an additional 41 CHWs from SSQH-CS NGO and ZC sites were underway. An additional 55 persons will be identified in first quarter PY3. These 96 individuals will be trained in all 5 MSPP ASPC modules, which together entail a total of 50 days training.

¹¹ CommCare is the open source mobile platform on which the mSanté application was built.

¹² HIFIVE provided \$50,000 to support mSanté.

enough to fit in a shirt or trouser pocket -- about half the cost, and more durable than the tablets for mSanté purposes.

During PY2, the mSanté applications were revised periodically to include software updates and to incorporate valuable feedback from users in the field. Project management also requested that an application be developed to facilitate and support SSQH-CS community health HIV activities. The project's mSanté advisors provided regular on-site mentoring and trouble-shooting for the 300+ ASPCs trained during PY1 to familiarize ASPCs with app changes, and conducted formal training for an additional 235 individuals (128 CHWs -- includes 57 trained on the new HIV app who had been trained in mSanté PY1-- and 107 supervisors). Ambitious training plans for PY3 target 620 CHWs and an additional number of supervisors to be determined.

In the last quarter of PY2, SSQH-CS enlisted community health worker involvement in HIV work, as part of the project's HIV boost strategy. This was in response to a growing perceived need to facilitate care and treatment for HIV+ patients at the household and community levels, as well as to seek out HIV LTFU patients and discreetly get them, and their families in some cases, into appropriate care. To this end, SSQH-CS developed a community health HIV module and piloted it at two NGO sites in July and August 2105 (initially at ICC Grace Hospital, and subsequently at FONDEFH Delmas 75). A total of 20 staffers (8 at ICC, 12 at Delmas 75) participated in the pilot activities. The successful pilots informed further revision of the HIV app.

With the start-up of the USAID Linkages project¹³ in the second half of PY2, SSQH-CS devoted heightened attention to the needs of commercial sex workers (CHWs) and men who have sex with men (MSMs). The Linkages-SSQH collaboration calls for Linkages community health workers to identify persons in need and refer them to SSQH-supported institutions for appropriate HIV services. Based on discussions with Linkages, with FOSREF and with SSQH-CS HIV sites, the project may further modify mSanté in PY3 to include an app for work with CSWs, MSMs, and with youth, budget permitting.

During the reporting period, SSQH-CS met with Jhpiego representatives regarding sharing of the mSanté suite of applications and tools for use by the Jhpiego-managed SSQH-North project. By the end of the reporting period, a Memorandum of Understanding had been drafted and submitted to both Pathfinder International and Jhpiego headquarters for review and approval. Several planning meetings were also held with Jhpiego staffers to jumpstart Jhpiego's orientation to mSanté.

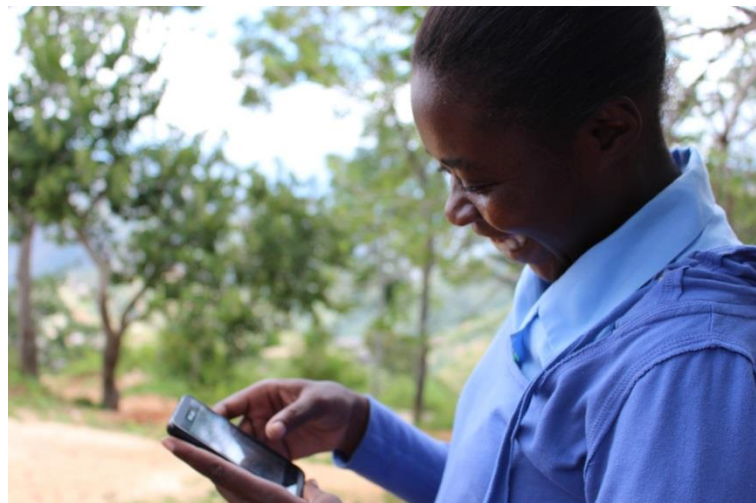


Figure 3: An ASCP uses CommCare to support the delivery of services

¹³ Linkages aims to conduct a range of activities to reduce HIV transmission among key populations — sex workers, men who have sex with men, transgender persons and people who inject drugs — and to improve their enrollment and retention in care.

Also in the second half of PY2, SSQH-CS mSanté advisors met with top MSPP officials¹⁴ to provide a comprehensive update on progress made and lessons learned during the first 18 months implementation of mSanté in Haiti. SSQH-CS was able to clear up the misunderstanding that the mSanté platform was a parallel system that was not congruent with MSPP's national health management information system (HMIS). In this regard, SSQH-CS advisors demonstrated that mSanté has the potential to feed directly into the MSPP's DHIS2-based national HMIS thereby eliminating opportunities for data reporting errors that commonly occur as CHW service statistics are transferred manually by individual CHWs from registers to reports.

Just prior to the end of the reporting period, SSQH-CS mSanté advisors met with CDC representatives responsible for iSanté work in Haiti to discuss areas of mutual interest. Designed by I-TECH to standardize HIV patient records, iSanté is an electronic medical record (EMR) system that started with the implementation of standardized paper records, based on national treatment guidelines. Initial meetings were fruitful and plans were made for more in-depth discussion of possible future collaboration and interface between iSanté and mSanté.

Mobile Health - mSanté Next Steps

In PY3, a total of 450 ASCPs will be trained in mSanté. SSQH-CS will procure additional mobile phones for newly trained ASCPs. Use of tablets will be phased out as new phones become available for ASCP field staff. A plan for alternative use of the tablets will be finalized and implemented, e.g., redistributed to facility-based staff (supervisors, program coordinators, data entry and/or logistics staff) and appropriate training in their use provided.

SSQH-CS will continue to collaborate closely with MSPP/UEP to ensure that mSanté conforms with national HMIS requirements. The mSanté app will be modified to enable consolidated reports on ASCP service statistics that can be transferred to ASCP supervisors on a monthly basis. A comparable revised ASCP supervisor module will permit supervisors to view monthly service statistics from all ASCPs under their charge, thus facilitating the transfer of aggregated data on community health services to the facility data clerk for submission into DHIS2.

After several meetings with partners, and USAID and CDC officials it was determined that the idea of a potential integration of mSanté with iSanté was worth pursuing further. Follow up discussions and meetings will be held in early PY3 to study and better understand the technical and budgetary requirements necessary for such potential integration.

SSQH-CS will continue to coordinate and collaborate with the MSPP to ensure that the mSanté app remains relevant and useful for Haiti's health sector work force. The project will also continue to work other USAID partners (Linkages, Jhpiego) and with other interested parties (e.g., The Tripartite Cooperation Brazil-Cuba-Haiti) to pursue opportunities to strengthen the capacity of additional numbers of community health workers through use of mSanté.

¹⁴ SSQH-CS met with MSPP UEP (Unité d'Évaluation des Projets) officials and with the Minister of Health's Cabinet Technical Advisor for Community Health.

POINT-OF-CARE DIAGNOSTICS FOR HIV/TB

Strong gains were made in support of HIV/TB point-of-care diagnostic capacity building in PY2. The project also implemented plans made during Y1 to develop “hub” facilities for point-of-care CD4 diagnostics. Based on PNLs site-level recommendations to establish CD4 capacities, SSQH-CS made suggestions to help identify an appropriate site for a PIMA CD4 unit within the SSQH-CS network. The project was successful in lobbying PNLs and the National Lab to select CS Dame Marie in Grand Anse for the site. SSHQ-CS coordinated with SCMS to deliver the unit and provided laboratory and clinical mentoring to capacitate facility providers. As a hub facility, Dame Marie serves populations in the Abricots area. The addition of this diagnostic function at Dame Marie brings the number of SSQH-CS network referral sites using diagnostic units to 18.

MOBILE MENTORSHIP TEAMS

Since the end of PY1, the project has deployed mobile mentorship teams (MMT) to select facilities. Originally capacitated to provide mentorship in HIV/TB, the MMT has expanded its role to provide onsite and extended mentorship to doctors, nurses, and lab technicians in FP and MCH integrated services. During the PY2, the MMTs provided mentorship visits to seven facilities. Working side-by-side with facility personnel, the MMT reviewed the use of registers, assessed how well providers followed established protocols and guidelines, and mentored staff on new HIV services recently added to the target sites. Commodity stocks and consumption reports, MSPP registers, and individual patient charts were also included in the review. The MMT made recommendations to the facility management and shared them with SSQH-CS technical advisors as appropriate to enlist support for follow-up actions.

In general, the MMT recommendations covered needed improvements that could be made on-site as well as larger systemic challenges facing the facility. Issues such as insufficient staff, lack of electricity, or insufficient equipment (e.g., lab or computer hardware) were often beyond the means of the project to resolve. Thus, when USAID offered to procure some supplies and equipment for SSQH sites through another USAID project (LMG), SSQH-CS provided a long list of items needed for specific sites and submitted it to USAID in July 2015. USAID anticipates that the equipment may be available in December 2015.

By the end of PY2, it became apparent to SSQH-CS management that for all intents and purposes, the MMT was in fact functioning similarly to the IMTs (integrated mentoring teams), which themselves had transitioned from focusing largely on management, logistical and financial issues to providing mentoring in technical clinical areas as well, following priorities articulated in facility CQI plans. As the project moves forward, the IMTs will be the primary vehicle for providing assistance to DDS and NGO partners. SSQH-CS will continue to promote and support DDS participation during all IMT site visits.

Objective 2 Next Steps

During PY3, SSQH-CS will continue to support ASCP trainings and scale up of the mSanté program. Inclusion of HIV in future ASCP trainings is a given. Upon completion of the MSPP CHW modules, successful trainees will be certified as ASCPs. SSQH-CS will coordinate with the MSPP and the DDS and will help organize and support ASCP certification ceremonies to be held at the department level. The project will continue to rely on an all-inclusive IMT approach to provide a wide breadth of technical assistance to DDS and ZC and NGO partners.

OBJECTIVE 3

FACILITATE THE SUSTAINABLE DELIVERY OF QUALITY HEALTH SERVICES THROUGH THE INSTITUTIONALIZATION OF KEY MANAGEMENT PRACTICES AT FACILITY AND COMMUNITY LEVELS

Semester Highlights

- ✓ 100% sites with CQI plans that incorporate a system to identify and follow-up on issues
 - ✓ 100% DDS have CQI committees in place and functioning
 - ✓ 91.3% sites maintaining auditable monthly financial reports

SSQH-CS made significant progress during the year with both department- and facility-level personnel in improving key management practices. A combination of mentoring visits, joint supervision, focused trainings, and capacity workshops helped facility and department personnel identify management and service quality needs, develop continuous improvement plans, improve data collection and reporting capacities, and increase competencies in financial and commodity management. The project refined its site profile dashboard, which draws from assessment data collected in Y1, and presented it and data analyses to the departments in a series of workshops to engage all six DDS with their data and inform decision-making.

CONTINUOUS QUALITY IMPROVEMENT

The SSQH-CS approach to supporting continuous quality improvement (CQI) builds upon established national quality management efforts (HEATHQUAL) where appropriate, and draws from performance goals set by the facilities themselves. Project staff worked with the HEATHQUAL team to expand the platform to include non-HIV content, including other service programs like FP and MCH as well as management issues. Concurrent to this process, the project helped facilities design or refine CQI plans that can eventually streamline with HEALTHQUAL. Using Deloitte's participatory CYPRESS model to help facilities translate performance targets into capacity development actions to improve health system performance, SSQH-CS helped facilities identify goals and deficiencies obstructing their attainment. Workshops designed to present CQI and joint supervision planning engaged facility and DDS staff from all six departments. These activities covered CQI exercises and tools, health indicator lists, orientation to joint supervision, and data collection and use for decision-making. By the end of Y2, all 80 facilities had CQI plans developed and quality committees established (including identified members, roles and responsibilities, and next quality meetings); and all six DDS developed joint supervision plans.

Once CQI plans were established at sites, the project continued to work with facilities to further refine and customize the plans to improve service delivery. Working with 22 PEPFAR-supported sites, SSQH-CS helped them expand their CQI plans to include an HIV service improvement steps. These 22 sites also reviewed their quality committees and their TOR functions using recommendations from the project. All project PEPFAR sites, via the EMR, will be able to automatize for analysis data generated during the implementation of their CQI plans, which allows them to monitor service delivery results.

FINANCIAL SYSTEMS

Building off some early successes in Y1 with financial reporting for a number of the NGO-supported facilities, the project expanded its engagement on facility and department financial systems strengthening. The project surveyed financial procedures and documentation maintained at a sample of the four different levels of ZC facilities in Center and Nippes departments (dispensary, CSL, CAL, and referral hospital) and found inconsistent availability of MSPP guidelines on financial reporting and weak bank reconciliation and expenditures tracking practices. With this information, advisors drafted standardized financial management models by facility type that vary in terms of reporting responsibilities yet are simplified and promote increased transparency and controls. The project collaborated with USAID/HFG¹⁵ and SSQH-Nord to adapt national system tools and processes to allow sites to present auditable financial reports. Capacity building workshops with DDS staff and the project's six financial managers (one assigned to each target DDS) introduced financial management objectives and trained participants in tools (i.e. bank reconciliation forms and auditable financial statement formats), procedures, and manuals. The financial managers at each department are now custodians of these tools and processes and liaise with DDS staff directly. The project provides routine follow-up mentoring with these finance managers. The departmental finance staff developed training schedules for next semester to roll out financial management tools and processes to facility staff.

Not only is SSQH-CS achieving expected results for the contract, but we are supporting the roll out of national financial management policies and procedures in collaboration with the MSPP and other key USAID implementing partners. Six SSQH-CS financial advisors embedded at the DDS and six DDS accounting employees have been trained during three workshops. These participants support these sites on the national system tools and mechanisms in order to achieve annual targets. Facility and DDS participants used practical exercises in a range of supporting financial tools such as bank reconciliations, petty cash books, routine financial reporting, etc. All DDS organizations are now receiving and tracking the receipt of auditable financial reports from their ZC facilities. The project continues to receive auditable financial reports from its NGO facilities as a part of their standard reporting requirements for the project.

During the year, the project saw the number of facilities producing auditable financial statements increased 41 in Y1 to 73 in Y2, which represents 91.3% of the Y2 target achieved. This included a 100% success rate for NGO-managed facilities, a success supported by making financial statements a sub-contract deliverable. With ZCs, the project had to adjust its approach since it does not have the contractual leverage it shares with the NGOs¹⁶. To help ZC facilities maintain auditable financial statements, the project works through the embedded finance managers and DDS staff to collect, track, and support reports in all six departments. ZCs had an 80% success rate for the year for this indicator.

CLINICAL RECORD SYSTEMS

Project advisors supported service providers in maintaining and using complete patient files during supportive supervision and mentoring visits. They reviewed existing files for completeness with providers, advised them on how to improve the quality of records, and mentored them in the use of the

¹⁵ Health Finance and Governance Project

¹⁶ The project has subcontracts with NGOs and MOUs with Departments for service delivery at ZCs. SSQH-CS made financial statements a deliverable under the NGO subcontract. However, the MOU mechanism does not enable a financial statement deliverable since expenses are not paid directly to departments or facilities.

data for improved service quality and reporting. DQA visits verified data transposition into registers and helped data clerks authenticate monthly statistical reports.

HEALTHCARE WASTE MANAGEMENT

Governance and leadership support provided to sites by the project incorporated elements of healthcare waste management. Participatory methods engaged facility staff in developing action plans that address capacity to receive, manage, and dispose of health commodities. More support in this area will be necessary as the project moves forward to ensure sites have efficient resources to monitor and manage healthcare waste management. All NGO and DDS service delivery agreements include regulations and guidance on proper waste management. See EMPR section under *Management, Monitoring, and Administration* section for more.

DATA MANAGEMENT

The project supports service providers in data collection, management, and reporting through onsite mentoring and data validation exercises, and remote follow-up assistance. Data reporting TA helped providers accurately record results in both MESI and MSPP registers, as well as compiling data for monthly statistical reports for the project. SSQH-CS M&E officers conducted data quality validation site visits for 35 facilities (including 88% of ART sites), testing results for selected HIV, TB, and FP indicators. These visits also enabled the project to record data for selected HIV/TB indicators reported in MESI, such as the 12-month ART retention rate. Project advisors also supported the development and roll-out of new MSPP facility registers; 35 facilities received registers and training on how to properly complete forms, collect data, store, and submit to the project.

Key impacts for the year include all 80 facilities and six DDS use the national M&E reporting system; sectorial tables have been established in all six departments, in which DDS and UAS representatives review project performance for all partners and use the information generated by these reviews for the next year planning; and improved availability of registers and reporting forms.

INFECTION CONTROL

As part of the project's TA for HIV/TB services, advisors worked with facility staff to reinforce the presence and implementation of TB-infection control standards and protocols. For TB sites without an infection control plan, the advisors helped facility staff develop one using a project-designed template [see Obj. 1 TB for detail]. Onsite mentoring visits provide regular verification that plans are in place at facilities; and follow-up supervision visits to providers are conducted to monitor implementation. While the total number of facilities with plans is higher, only 34 are actively implementing infection control plans. A chronic lack of basic infection control supplies hampers execution of the plans. SSQH-CS coordinates with SCMS and other partners in an effort to obtain supplies but quantities needed are often not available. To encourage implementation of the plans until a more sustainable solution is identified, SSQH-CS is considering the procurement of some supplies and making them available to project-participating sites.

PERSONNEL MANAGEMENT

Site-focused improvement workshops in the South department helped facility personnel identify and design solutions to management and leadership challenges such as weak morale, low performance, and constant absenteeism. Using the CYPRESS methodology, project advisors facilitated a participatory process in which facility personnel from Les Anglais developed a site/organizational chart and job descriptions, identified roles and responsibilities, created a framework for talent development plans for staff. The process empowered facility staff to make the changes themselves and an output from the workshop was the participatory development of an improvement plan to address leadership, vision, human resources management, commodities/supply chain management, and financial management. While this approach was very productive and helpful for facility staff, the level of effort for conducting individual site-focused workshops does not make a scalable model to reach all project facilities. However, the project maintained support for personnel management in the larger, departmental-focused capacity building workshops held in the first semester.

SUPERVISION

Supervision support is directly integrated with the project's CQI support. Workshops hosting departmental heads and facility personnel included the development of joint supervision team visit plans. SSQH-CS assisted representatives from the DDS to develop supervision schedules and budgets. Over the course of the year, 78 sites received a total of 226 supervision visits from project advisors and DDS/UAS coordinators. Tracking tools used by technical teams conducting the supervision visits helps ensure recommendations are followed up and impediments to service delivery addressed. In collaboration with MSPP, SSQH-CS adapted the Supervision Checklist Tool to incorporate additional components such as community-based activities, facility-based service delivery, commodity and logistics, and CQI. This enhanced checklist will help to raise awareness on the importance of health systems strengthening approaches for improving health outcomes.



Figure 4: Les Anglais facility personnel during workshop

Key impact from the project's support for supervision includes an increased leadership by the DDS in formally supervising NGO service delivery activities, which is significant as traditionally they have not played a formative role overseeing partner activities, and recommendations made from supervision visits are followed-up by DDS focal points.

SUPPLY-CHAIN MANAGEMENT

SSQH-CS continued to support supply chain management at the facility level and liaised with DPEV and SCMS to ensure adequate stock of health commodities. Facilities submit monthly commodity consumption reports to the project and advisors help identify low inventory levels and follow-up support on resupplying. The accurate and timely submission of consumption reports plays a critical role in reducing stock outs at facilities and enables sites to enter additional orders of commodities when prior SCMS deliveries do not align with demand. Onsite TA builds the capacity of facility logisticians in commodity management. Project support at 16 facilities and follow-up trainings for 9 sites during the semester assessed capacities and developed action plans to help facilities receive, manage, and dispose of health commodities. Twenty-five (25) sites received training in job aids, stock cards, forecasting methods, and consumption reporting. During the semester, all 26 HIV sites experienced no stock outs of HIV or three essential OI commodities, and the project saw a 93% timely consumption rate for HIV commodities at HIV facilities. Additionally, the project has reached 87.8% of its annual target in percent of sites experiencing stock outs of vital products.

One issue experienced in the period was the distribution of expired TB medication to facilities. Once identified by the project, the SSQH-CS team worked swiftly with the sites receiving the expired medication and supply chain stakeholders to discontinue use of expired TB drugs and request immediate shipment of valid drugs. Ultimately, by effectively managing the situation, SSQH-CS was able to prevent a stock out of TB drugs at multiple priority HIV sites. In another instance, when vaccine stock outs were experienced in the West department, the project coordinated with the site in question, with the DDS, UAS, UCS, and DPEV to identify needs and facilitated delivery of stocks as appropriate.

SSQH-CS has developed a comprehensive procurement and distribution strategy for improving distribution of vaccine commodities amongst facilities in West department where stock outs have occurred frequently. To complete this strategy, the project conducted a forecasting exercise with facilities. Secondly, the project supported West department facilities to communicate forecasted needs to UAS, UCS, and DDS. Third, these three entities submit the procurement request to DPEV for approval. DPEV, upon approval, sends the procurement request to the central medical stores. Finally, the project secured an agreement with SADA Matheux to distribute vaccine commodities to ZC facilities in the West department.

Objective 3 Next Steps

Given the many achievements reached with establishing and implanting CQI teams and facility plans, PY3 will support the focus of these resources to sharpen service management and quality. Commodity management will need ongoing support, with emphasis on forecast and consumption reporting and stock management training. Ongoing support for improved site financial management capacity will help facilities better manages resources for peak performance.

OBJECTIVE 4

STRENGTHEN DEPARTMENTAL HEALTH AUTHORITIES' CAPACITY TO MANAGE AND MONITOR SERVICE DELIVERY

Semester Highlights:

- ✓ 120% of Y2 target met for sites that address recommendations from site visits
- ✓ 133% of Y2 target met for DDS that hold meetings quarterly to analyze data for programming
- ✓ 57 sites received 4 comprehensive supervision visits and reports by DDS staff

SUPPORTING DEVELOPMENT OF DEPARTMENTAL MANAGEMENT SYSTEMS

The second half of Y2 saw important gains in SSQH-CS's capacity building activities with the DDS. The project invested in departmental budgeting and planning, awareness and utilization of data systems, and strengthening and systematizing supervision. Preparation for implementing the MSPP's RBF scheme continued at sites as SSQH-CS collaborated with USAID to find an appropriate mechanism for RBF contracting.

Departmental Budgeting and Planning

In the beginning of PY2, SSQH-CS assisted each DDS in preparing their workplans and budgets for the year's activities. The project asked departments to submit their individual workplans ahead of the project's annual workplan submission to USAID. DDS activities that clearly coincide with SSQH-CS objectives and priorities were then incorporated into the project workplan, taking into account budget and other needs and considerations specific to each DDS. This helped to ensure that SSQH-CS activities aligned with the DDS integrated plan, or plan départementale intégré (PDI), which outline the DDS's multi-year strategies and goals. In hand with this process, the project reviewed and agreed upon joint DDS budgets which the project would support. SSQH-CS staff focused on: standardizing costs across budget items (e.g., gasoline, insurance, confirming staff are paid at least the minimum wage, etc.) and ensuring that mandated SSQH-CS activities such as trainings, mobile clinics, and supervision visits were included.

In February, the project held a department-wide workshop that included DDS and ZC personnel. All six department directors and representatives from 10 ZCs joined SSQH-CS staff to disseminate project documents; clarify payment mechanism and documentation requirements; discuss ZC personnel benefit eligibility; reinforce the DDS in their role in supervision, regulation, and management; reinforce ZC-managed community activities; outline communication lines between DDS and project; and address any burning issues/questions. The workshop also provided updated guidance on M&E support and RBF rollout.



Figure 5: Participants from 6 DDS and 10 ZCs met in Petion-ville in February 2015

Data Use for Decision-Making

SSQH-CS developed two tools during Y1 to better facilitate project, department, and facility data use and analysis. The Site Profile and Data Dashboards use site assessment data and are designed to house updated data from site visits with the goal of sharing this with departments and facilities for decision-making. During the semester, the project expanded the database to include information on the availability, accessibility, and use of national protocols at SSQH sites. The inclusion of these criteria will assist the project team and departments in monitoring and improving site utilization of national norms and protocols.

Capacity building workshops held in March hosted 106 representatives from all six departments, including 10 UAS/UCS representatives and covered the importance of data, how to use facility data for decision-making, and presented the existing SSQH-CS tools (mentioned above) to demonstrate how the project currently uses facility data. In the Pre/Post-test of the workshop, participants showed significant improvement in the area of using data for decision making (moving from a 4.69/10 to a 7.41/10). In the future, review of the Site Profile and Data Dashboard will be folded into SSQH-CS's participation in the annual Table Sectorial for each department, therefore reinforcing the practice of data review and analysis in departmental planning. In future quarters, project staff will review indicator and financial management results with each department individually.

Supervision:

Support for joint supervision site visits involving DDS personnel continued during Y2 and focus has been to invest in supervision as a function owned and led by the departments. The capacity building workshops referenced above included supervision as a key topic, defining the term for participants¹⁷, developing supervision plans, and training participants on supervision tools and key practices. These

¹⁷ MSSP defines supervision as: "Routine supervision to assess strengths and weaknesses, provide immediate guidance, and make recommendations; monitoring to assess the effects of routine supervision and check how the recommendations were taken into account; and support or special supervision to support the level supervised in solving problems whose solution requires special support and guidance." Manuel de Supervision: A l'usage des Directions Centrales, Départementales, UCS et Institutions de Soins, MSPP, July 2008.

workshops were essential steps to further building collaboration with the six DDS and making progress on quarterly supervision of sites. During the workshop, five DDS developed supervision plans for all facilities in their regions, included both public and privately run facilities. Only the Central Plateau department missed the supervision planning session and could not develop a plan during the workshop. The project followed up with the department after the workshops to facilitate the completion of the plan.

The supervision tools used by the project have gone through several rounds of discussion and adaptation with MSPP. The process first began with a review of MSPP's Supervision Manual with ministry personnel and recommendations for specific tools, including the development of a checklist to streamline and improve supervision visits by raising awareness of HSS approaches for improving health outcomes. Subsequent efforts in collaboration with MSPP yielded adaptations to the Supervision Checklist tool to include additional components such as community-based activities, facility-based service delivery, commodity and logistics, and CQI. Project staff also adapted a USAID tracking tool for use in the DDS supervision. The checklist and tracking tool were introduced and explained during the capacity building workshops with the DDS. The project looks to roll out the updated supervision tool in coordination with the DDS soon, and main foci will be to streamline and standardize the process of conducting supervision visits while improving effectiveness of those visits.

A final aspect of the workshops for DDS, UAS, and facility representatives covered supervision topics such as how to better plan and execute site visits, and how to address issues identified during the visits. Next semester, the project will continue to work with the DDS in the implementation of their supervision plans, including continued joint supervision visits with the DDS and UAS representatives.

Systematizing Continuous Quality Improvement

To facilitate the integration of DDS with the site-level CQI process, the project drafted a scope of work for departmental quality committees. This SOW includes coordination, monitoring and evaluation of QI implementation within the department, and advising MSPP on QI policy and strategies nationally. In Grande Anse, the DDS piloted the SOW with its newly formed quality committee. The quality committees will be launched for the remaining five DDS next semester. As supervision visits continue, project advisors in coordination with DDS quality committees will develop plans for how to identify QI opportunities at facilities, track progress made, and document lessons learned. This will be further reinforced by the CQI plans themselves, which require facility staff to identify improvement opportunities and incremental steps to make progress in the area.

RESULTS-BASED FINANCING

RBF Financing, Implementation Approach and Contracting Mechanism:

SSQH-CS and USAID have discussed the challenges facing implementation of the MSPP RBF scheme under the project's contract since Y1. The main challenges are that 1) under the RBF scheme, both operational and incentive costs fall on the implementing partner, creating a financial constraint for the project and 2) per the project contract, SSQH-CS cannot enter into a direct subcontracting relationship with GOH entities, thereby preventing the project from directly transferring cash incentives under RBF to ZC facilities.

The project developed two concept notes in Y1 for USAID to consider. One note developed three possible RBF implementation scenarios that could operate within the project's budget. These scenarios involved reducing the amount of operational costs, capping RBF incentive payments, and phasing RBF

rollout by department. A second concept note explored potential contracting mechanisms the project could employ to implement RBF at the ZCs. A conclusive finding of this note confirmed that Fixed Obligation Grants (FOGs) would not be appropriate for RBF because it would be impossible to establish pre-determined milestones for service delivery.

In October, USAID conducted a two-day RBF workshop with the two SSQH consortia and USAID/LMG. Together, the participants discussed challenges and potential solutions for implementing RBF as designed by MSPP. SSQH-CS presented proposed implementation plans and budget analyses. Post-workshop, the project submitted a revised implementation concept note based upon the workshop discussion, which included a proposed 10% reduction to all service delivery budgets in order to free funding for RBF incentive payments. This would be implemented at 30 facilities over Y2 and Y3, with 11 starting in Y2.

Due to the fact that the SSQH projects are prohibited from contracting with GOH agencies directly and that both projects would need to reduce funding from current service delivery budgets in order to provide funding to RBF incentive payments, USAID determined the best avenue was for it to pursue the option of managing RBF contracts and payments itself. Under this scenario, SSQH projects would support RBF in implementation, training, and follow up, but not manage incentive payments. In February, SSQH-CS followed up on the status of this transition, and learned that USAID-MSPP discussions on the subject were still ongoing. The SSQH-CS team remains available to assist USAID and MSPP to finalize the payment mechanism processes, procedures and implementation plans.

RBF Implementation

Concurrent to the above process, SSQH-CS began its rollout of RBF preparation to the 11 facilities. All 11 facilities received orientation and training in RBF implementation during a week-long workshop in Grand-Anse and Nippes departments. Facility and DDS staff participated and the training included orientation on the RBF Working Group's (GTT) standardized tools, procedures, and indicators. Post-workshop support by project staff helped the 11 facilities finalize their business plans and budget provisions for RBF. Comités de Pilotage (CDP) were established in both DDS Grand Anse and Nippes and received support materials (SOW and monitoring tools) and orientation in their use.

Four additional sites from the South were identified for the anticipated RBF launch during Y3, bringing the total planned to begin the MSPP scheme to 15. SSQH-CS continues to play a leadership role on the MSPP's RBF technical working group through participation in the impact evaluation study design and guidance for RBF roll-out nationally. We continue to work with stakeholders to review lessons learned from the North's RBF pilot and from the current roll out to support a successful launch of the RBF as soon as funding mechanisms are finalized.

Objective 4 Next Steps

During the next year, SSQH-CS will continue to coordinate with USAID and MSPP in the implementation of RBF to the 15 facilities in Nippes and Grand Anse. Ongoing support for implantation of the DDS supervision plans is critical for the next semester, while review sessions to assess success of these supervisions visits will help strengthen their effectiveness. Also essential to this process is to support the improvement of DDS capacities to analyze data and reporting, which the project will support through mentoring and workshops. Finally, SSQH-CS will work with site QI committees to identify quality improvement opportunities.

MANAGEMENT, MONITORING, AND ADMINISTRATION

SSQH-CS supports MSPP in the improvement of the health status of the Haitian population. The project does this in close collaboration with USAID, local implementing partners, and other USG partners. PY2 saw a further scale up of activities, a renewed and more collaborative partnership with the six DDS and service delivery partners, and improved integration of technical assistance in support of facility- and community-based services.

PROJECT MANAGEMENT

During the first half of PY2, SSQH-CS technical support was devoted largely to promoting and improving integrated services. In November 2014, SSQH-CS held an implementing partners' planning meeting to review the successes and challenges encountered in PY1 and to discuss, as a group, project management, strategy, and coordination moving forward. Discussions resulted in the designation of six integrated management teams (IMT) to liaise directly with DDS counterparts for the provision of TA. The IMTs include a mix of clinical and management advisors to deliver an integrated package of technical support at health facilities and departments. The project revised the name to "mentoring" teams since more aptly reflected the role they play vis-à-vis facility and department staff.

Also during the second semester, SSQH-management responded to new PEPFAR funding priorities and placed heightened attention on increasing SSQH HIV/AIDS program results. Consequently, an HIV program "boost" strategy was developed by the project's HIV advisors and funds were made available to reinforce existing HIV activities and support training and deployment of community health field agents to follow HIV clients in the community, track and recover LTFU, OVC, and through health education efforts reduce stigmatization of HIV+ individuals.

Without exception, contract deliverables are on track and include: the PY2 work plan, a revised PMP¹⁸, FY14 APR and SNU reporting, PEPFAR quarterly reports, PY2 service delivery subcontracts, PY2 USG Compliance activity matrix, and quarterly financial reports. Key deliverables such as the PY1 annual report and PY2 work plan were translated into French and shared with MSPP counterparts. Project management also provided comprehensive documentation and responses to the USAID OIG auditors who conducted a program audit of SSQH-CS in April 2015.

In February 2015, the USAID Acquisition and Assistance Office invited Pathfinder to meet and discuss project performance and challenges to date. Key topics covered during this meeting included the need for clarity on setting project targets in alignment with the contract versus annual the PEPFAR COP and a request that USAID consider allocation of additional funds to the contract offset the unanticipated cost impacts of salary "support" for 694 ZC service providers. During the reporting period, Pathfinder articulated these concerns in written correspondence to USAID, and fielded senior headquarters staffers to Haiti to discuss the issues at length. While the project targets issue was appropriately clarified via SSQH contract modification 4, the request for additional funds had not been resolved by the end of the reporting period. Pathfinder remains optimistic that the matter will be resolved early in PY3 to the mutual satisfaction of both parties.

¹⁸ Work plan and PMP were approved by USAID in July 2015.

Finally, the project's Change Log is designed to capture changes to its scope, budget, and/or timeline. Each of these changes has an impact on either facilitating or challenging the attainment of project's results.

Change	Summary of Change	Date Received	Cost Impact
Payment of salaries for health providers at ZCs	The project was asked to pay the salaries of 694 staff from ZCs in an effort to continue service delivery. These costs were unbudgeted and unforeseen as late as February 2014. This cost burden greatly reduces the project's ability to invest in other programmatic activities.	November 2013 Still not resolved by end of PY2	c.\$2 million annually
Budget shifts in PEPFAR funds	Budget decreases in HIV prevention (PMTCT, prevention, Lab, and HSS) and increases in treatment and care (adult, pediatric, HIV/TB, OVC), per PEPFAR mandate, for COP 2014 (FY15).	May 2014	Increased PEPFAR funds by \$484,861 while realigning areas supported
Addition of non-contract-mandated indicators to PMP	At USAID's request, the project has added 15 indicators to the Y1 PMP. These include PEPFAR and EPCMD indicators that go beyond the expected results in the contract. In certain cases, indicators for which the project implements no direct supporting activities have been included.	November 2014 – Present Issue resolved in July 2015 via contract mod 4	Revision of data collection tools; retraining of CHWs and HPs on collecting data; increased reporting burden.

Table 8: Project Change Log

MONITORING SYSTEMS

Data Reporting Systems

During the first half of Y2, SSQH-CS, at the request of USAID, revised the project Performance Monitoring Plan (PMP). The team reviewed indicator definitions and calculation processes established in the Performance Indicator Reference Sheet (PIRS) to ensure that indicators appropriately draw from the national system registers and, subsequently, national health management information systems MESI (for PEPFAR service delivery indicators) and DHIS2 (for non-PEPFAR service delivery indicators). By using these data sources, the project reinforces MSPP's national HMIS and avoids the inefficiencies and redundancies of creating a parallel monitoring system. To capture and monitor data generated for non-service delivery indicators (largely Obj. 2 – 4, but not exclusively), the project designed data collection forms to be completed by relevant consortium partners, to by contracted third parties as necessary. Submitted reports are accompanied with supporting documentation such as training participant lists or other project records to verify indicator results. Many indicators require site visits, as the national reporting systems do not capture them. Such is the case for indicators measuring adherence or the number of people enrolled in TB. The project plans to capture other non-clinical indicators through an electronic TA and site visit database. This database will house data and related supporting documentation not captured through the national HMIS. As part of the PMP revision process and per the request of USAID, the project added ten (10) new PEPFAR and five (5) new Ending Preventable Maternal and Child Deaths indicators.

System Strengthening

A major focus for SSQH-CS the year has been to strengthen the quality of data within the project's performance monitoring system. The team engaged in several data quality assessment (DQA) activities this semester designed to improve data recording and reporting at facilities so as to strengthen the national HMIS. Desk reviews of site-level monthly statistical reports, data entry for 80 facilities into

DHIS2, and register and M&E system reviews and mentoring at 21 facilities aimed to improve the quality of data uploaded to the national HMIS. In December, the project engaged an external DQA team to validate Y1 results in 8 project-supported facilities. All these activities have helped strengthen the validity, reliability, and completeness of service data. Site visits included DDS M&E counterparts in order to strengthen their capacity to manage the data review and validation process.

Challenges

Despite making headway in strengthening the project's monitoring system and support for the national HMIS, several challenges strain the team's efforts and pose certain limitations to improving quality data management. A lack of registers at the facility level prevented some service statistics to be reported in full and limits the ability of facility managers and providers to effectively use data for decision-making. Additionally, facility personnel continue to need reinforcement in how to use MSPP registers, as some providers remain confused on how to record data for certain indicators (i.e., number of patient visits). Some personnel lack rigor in completing reporting forms and/or do not submit reports in a timely manner. More oversight is needed to ensure CHW statistics are properly and completely rolled up into facility reports. While SSQH-CS continues to work to address these factors, their presence remains and affects the project's data management.

Moreover, SSQH-CS performance monitoring system itself is not yet at full operational strength. While significant improvements in data quality and reliability have been made during the year, the SSQH-CS performance monitoring system requires further enhancement, particularly in the timely collection and verification of selected project data and data available only through surveys. Turnover in M&E leadership for the project is largely responsible for the shortcomings. Fortunately, the project's M&E now has strong leadership and vision for success in PY3.

ADMINISTRATION

In September 2015, as a cost-saving measure SSQH-CS closed its project office in Cayes. Recruitment of replacement personnel for four key personnel positions took longer than expected. By mid-year, the F&A Director and M&E Director positions were filled. While dozens of COP and Technical Director were vetted and interviewed, these positions were still vacant at the end of PY2. It is anticipated that the posts will be filled by qualified candidates early in PY3.

One of the SSQH partners, Zamni Lasante, decided to leave the consortium at the end of September 2015. Gheskio's one-year contract also concluded on September 30, 2015. The project moves forward into PY3 with five strong performing partners: PIH, Deloitte, FOSREF, CDS, and Dimagi. The project continues support to the original 19 NGO subcontractors and six DDS for service delivery at 80 facilities.

Mobile Money

Since the last quarter of Y1, SSQH-CS has used mobile money services as a means to pay health workers at ZCs in an effort to promote financial transparency and inclusion, while minimizing the project's administrative burden of paying 694 individuals. The project receives timesheets approved by departmental heads and verifies them before making payments. USAID has prioritized the use of mobile money in other sectors, and SSQH-CS is proud to bring it to the health sector. Under the Tcho Tcho Mobile program managed by Digicel the project makes salary payments to registered workers who then draw down funds from their account from an authorized vendor. By February/March 2015, the project was paying 558 workers via the program (those not paid via Tcho Tcho are done so by wire transfer).

The preceding notwithstanding, the use of this service is not problem-free and the project has identified some bottlenecks. A number of individuals have reported having trouble accessing funds in a timely manner. Tcho Tcho Mobile vendors may be located far from where some workers are stationed and accessing them requires traveling distances and returning with large sums of cash, a safety concern. Other times, authorized vendors may not have enough cash on hand to allow workers to fully withdraw their account, thereby causing them to have to return to access their money. SSQH-CS is working with Digicel to identify when and where these challenges occur, and the company has already responded with increasing the number of Tcho Tcho vendors. Still, other challenges prevent workers from accessing their funds on time. Several people have changed their telephone numbers without notifying the project, which causes a delay in accessing funds. SSQH-CS is working with the DDS to find ways to ensure that health workers do their part in order to receive their payments in a timely manner.

ENVIRONMENTAL COMPLIANCE

At the recommendation of USAID in mid-2014, SSQH-CS adopted the EMMP that had been in effect under earlier USAID integrated health projects. Previous projects had to address the same environmental issues currently faced by SSQH-CS and its participating health facilities. Like its predecessors, the majority of activities under SSQH-CS do not have negative impacts on Haiti's physical environment or on beneficiary populations and communities. However, there could be some negative impact on the environment if the different kinds of waste products generated by health facilities are not handled correctly according to recognized waste management standards.

SSQH-CS has two civil engineers on staff who advise on and monitor waste disposal, institutional hygiene and sanitation, and environmental maintenance of common grounds in and around SSQH-supported facilities. In 2014, structural assessments were carried out at 25 SSQH MCH/WASH sites. Criteria were established and applied in order to prioritize sites for eventual renovation work. Ten sites were initially selected. This number was reduced to six (based on different factors) and plans were made in early 2015 to contract for minor renovations at two high performing facilities in PAP (Delmas 75 and Martissant, both HIV saturation sites). However, contracting was delayed for internal logistical reasons.

In the meantime, the USAID/Haiti Health Office informed SSQH-CS that USAID had provided funds to another USAID project to carry out renovation works at health institutions throughout the country. SSQH-CS thus put its renovation plans on hold indefinitely. When it was learned several weeks later that the USAID project in question did not select Delmas 75 or Martissant for renovation work, SSQH-CS decided to proceed with the renovation work at these two sites in PY3. The contracts will require contractors to implement mitigation measures for rehabilitation/renovation work as necessary (e.g., workplace is protected and marked; site visitors are not disturbed; environment is not destroyed or contaminated, etc.). SSQH-CS engineers will also monitor the work on-site to make sure that contractors comply with work site safety and environmental mitigation measures.

Coaching/mentoring on environmental mitigation and infection control is done at all facilities, not just those that have been selected for renovation work. SSQH-CS WASH engineers make recommendations for simple low-cost environmental improvements both inside and outside project facilities. At one site (Petit Trou de Nippes), they discovered that a brand new sophisticated incinerator that had been donated by UNICEF had never been utilized because health facility staff had not been trained in its use. Facility staff had no knowledge of waste management procedures. SSQH provided information and helped arrange training for facility personnel. In a follow up visit to the site, the WASH team reported that the incinerator was being correctly used. They also noted that the grounds and facility itself had

been noticeably cleaned up per recommendations made by the team. Similarly, at the CS de St Joseph, it was noted that health authorities made significant improvements to the locale following recommendations made by the team. However, at other sites, it is clear that some funding is necessary to address basic infrastructure needs.

During PY3, SSQH-CS plans to allocate a modest amount of funding to address infection control, work place hygiene, and waste management gaps at approximately 25 sites, including sites offering TB services. Facility staff will receive training in these matters by the project's WASH engineers who will subsequently assist institution staff to plan and carry out building clean up and maintenance actions. Improvements in physical structures will be complemented by training by other SSQH specialists in, for example, stock management, record-keeping, client flow, continuous quality improvement, etc. Priority will be placed on ZC institutions that can demonstrate DDS support for minor "fixer up" work. This will constitute the sine qua non for SSQH to finance even modest infrastructure improvements at sites.

SUCCESS STORIES

A SECOND CHANCE FOR FAMILY PLANNING IN HAITI

Nicole is a proud family planning user. She knows how important it is to the health of her family, and how much it has improved her life.

But it hasn't always been that way.

She first learned about family planning in 2000 when she visited the FONDEFH Delmas 75 health clinic after the birth of her third child. After hearing about her options, she began using the injectable contraceptive called Depo-provera.

The 40-year-old single mother had been using depo for 1 year, but then everything changed. "I had a bad experience in 2000" she explains. "I was receiving my shot every three months, but I became pregnant. After that, I did not want to hear about family planning anymore." As a consequence, the family of the single mother increased with the birth of her fourth child, and the fruit vendor's wages were stretched even thinner. After that, she didn't trust the care at the clinic. A few years later, polyvalent community health worker Miss Mondesir started visiting her community. Nicole would see her in the market where she sells fruits and vegetables or in her neighborhood; she would listen as Miss Mondesir talked about HIV tests, family planning, nutrition, and hygiene. Miss Mondesir advised her to visit the clinic, to give it another chance. In late 2014, Nicole came back. She was still skeptical, but she trusted Miss Mondesir. She arrived at the clinic with a referral for family planning.

When she arrived, Miss Sheila, a nurse trained in long-acting family planning methods by SSQH-CS, spoke with her in detail about five family planning methods available to her. Nicole had never heard of long acting methods before, and decided to try an implant.

"Now, I feel more supported and I have confidence in the clinic."

Nicole knows that using a family planning method will help her to better manage her business and save money for her family.

“I have a dream to educate my son; I hope that he will become a doctor,” Nicole says proudly. “Family planning will allow me to have the time to make more money.”

ICC GRACE HOSPITAL MOVES THE NEEDLE ON IMPROVING QUALITY OF CARE PROCESSES FOR HIV PATIENTS

As healthcare systems around the world shift their focus to value-based care, patient experience and service quality have become an increasingly important component of healthcare delivery. In Haiti, improving HIV care and treatment practices is an important stepping-stone for achieving PEPFAR’s contributions towards and AIDS Free Generation.

ICC was having trouble sustaining ART adherence and retention among their patient population, in part due in part to a lack of internal quality improvement processes. Currently, 163 staff serve 2,308 PLHIV, 1,750 of whom are on ART. A performance report from its electronic patient management system showed that none of the 513 PLHIV on ART were evaluated for adherence to ART. Improving patient adherence is crucial to patient outcomes and reducing the risk for developing resistance to treatment and acquiring opportunistic infections. To address this challenge, a multidisciplinary team led by ICC staff initiated quality improvement activities for ART adherence.

ICC staff attended Quality Improvement workshops led by SSQH-CS to review their CQI plans and address adherence and retention challenges occurring at the hospital. During the workshops, SSQH-CS advisors facilitated a participatory group discussion with ICC about performance improvement objectives and activities, created a quality committee, and documented quality improvement opportunities at the facility. Once ICC developed a plan to monitor changes in adherence and retention, the CQI team organized follow-up activities with the hospital’s HIV staff to discuss site performance and strategize ways to improve key performance indicators. ICC tested various adjustments to the HIV model of care for short periods using the Plan-Do-Study-Act (PDSA) cycles that they had learned during the SSQH-CS Capacity Building workshops. Using this tool, the hospital made new service operation decisions in accordance with the data gathered and assessed from its performance reports.

CQI efforts supported the adoption of new routine practices, such as patient tracking, home visits, and staff orientation on adherence forms. Routine CQI sessions among HIV providers help them to identify root causes of low performance, such as missed appointments and poor tracking of patients. As a result, the hospital has implemented several key interventions:

- Maintaining lists of missed appointments and conducting routine follow-up with patients
- Filing and monitoring of adherence forms
- Hiring a new psychologist and social worker to assist with follow-up on adherence
- Increasing availability of IT equipment for electronic data entry

These key steps now help ICC on its way to improving its capacity to monitor adherence and take corrective actions as necessary in its support for HIV patients.

ANNEXES

A. SSQH-CS PMP Indicator Summary Table with Annual Results